No. 08- 08 989

IN THE
Supreme Court of the United States

HAROLD L. LEONARD
d/b/a THE LEONARD CLINIC OF CHIROPRACTIC,

Petitioner,

v.

EDUCATORS MUTUAL LIFE
INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Where the administrator of an ERISA benefit plan fails to exercise discretion in an eligibility determination, must the district court review a claim brought pursuant to 29 U.S.C. § 1132 *de novo*, in light of this Court's holdings in *Firestone Tire & Rubber Co. v. Bruch* and *Aetna Health Inc. v. Davila*?

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The decision of the United States Court of Appeals for the Third Circuit in *Harold L. Leonard d/b/a The Leonard Clinic of Chiropractic v. Educators Mutual Life Insurance Company* is an opinion that has not been published in an official reporter but can be found at 2008 U.S. App. LEXIS 23141. The Third Circuit affirmed the October 23, 2007 decision of the United States District Court for the Eastern District of Pennsylvania reported at 2007 U.S. Dist. LEXIS 78342; 42 Employee Benefits Cas. (BNA) 2583 (E.D. Pa. 2007). The United States District Court for the Eastern District of Pennsylvania, in an opinion that has not been published in an official reporter, confirmed federal subject matter jurisdiction at 2005 U.S. Dist. LEXIS 7941 (E.D. Pa., May 5, 2005). *See* Appendices A, B and C.

STATEMENT OF JURISDICTION

This Court has jurisdiction pursuant to 28 U.S.C. § 2101(c) as this is a petition for a Writ of Certiorari intended to bring before the Court a judgment in a civil action rendered by the United States Court of Appeals for the Third Circuit filed on November 4, 2008.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Employee Retirement Income Security Act of 1974
Title 29 United States Code, Section 1001(b)

> **Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries**
>
> (b) It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

Title 29 United States Code, Section 1132(a)(1)(B)

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

. . .

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

Title 29 United States Code, Section 1133

Claims Procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Title 29 Code of Federal Regulations, Section 2560.503-1(l)

> (l) Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

The provisions of 29 C.F.R. § 2560.503-1(f), C.F.R. § 2560.503-1(g), 29 C.F.R. § 2560.503-1(h) and 29 C.F.R. § 2560.503-1(h)(1999) are lengthy and, therefore, set out in Appendix D pursuant to Supreme Court Rule 14.1(f).

STATEMENT OF THE CASE

Petitioner, Dr. Harold L. Leonard ("Dr. Leonard"), commenced this action against Respondent, Educators Mutual Life Insurance Company ("Educators"), in the United States District Court for the Eastern District of Pennsylvania under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* to recover unpaid medical benefits under a group health insurance policy.

Dr. Leonard was a chiropractor who operated his practice as a solo practitioner, originally in Lancaster,

Pennsylvania. Dr. Leonard had health insurance under a group policy with Educators for which he was billed the insurance premiums each month. Educators reviewed and adjusted Dr. Leonard's policy annually. In the fall of 1993, Dr. Leonard resumed his education. In September 1995, he opened a chiropractic clinic in Ellicott City, Maryland. Dr. Leonard's wife, Diane, and others worked with him there and were also covered by the Educator's group policy. In June 1997, Diane Leonard moved out of the couple's Maryland residence and separated from him for the fifth time. Dr. Leonard and his wife had a history of reconciling their marital discord, so he therefore expected to eventually resolve any conflicts with his wife and that she would resume her duties at his clinic.

Dr. Leonard developed orthopedic problems which continued to worsen. By September 1998 he was forced to discontinue giving chiropractic treatments. Although he no longer treated patients, Dr. Leonard maintained HMO contracts and continued as a chiropractic consultant until the end of 2003. Effective January 30, 1999, Dr. Leonard requested, and was assigned to, another insurance broker, Paul Rovnak. Upon visiting Dr. Leonard's Lancaster clinic, Rovnak discovered it was closed and advised an Educators' representative. Rovnak was informed that Educators would "look into it." Educators subsequently informed Rovnak that Dr. Leonard was practicing in Ellicott City, Maryland. Rovnak believed that Educators would continue to provide coverage as long as Dr. Leonard maintained a Pennsylvania post office box. He advised Dr. Leonard of this and a post office box was opened.

In 1999 Diane Leonard was diagnosed with cancer. In January 2000, Dr. Leonard was diagnosed with heart disease. On at least two occasions during his treatment, Dr. Leonard had conversations with Educators regarding his medical problems, and Educators paid his medical claims. In February 2002, Educators announced that it was exiting the group health insurance market and would not renew health insurance policies that were expiring over the next 18 to 24 months. The termination date for Dr. Leonard's policy was July 31, 2003. Because of the various health problems suffered by Dr. Leonard and his wife, his monthly health insurance premiums saw a dramatic increase in price from $246.89 in 1998 to $1,601.28 in 2003 based on Educators' underwriting decisions. Dr. Leonard paid the Educators group insurance premium when due each month between February 1987 and July 31, 2003, and Educators accepted each of the premium payments.

In June 2003, Dr. Leonard was hospitalized on an emergency basis for heart bypass surgery. On July 14, 2003, while reviewing claims he submitted, Educators stopped all claim payments for both Dr. Leonard and Diane. Educators did not issue a notification of an adverse determination of Dr. Leonard's claim, but simply froze the account. Educators now alleges that they sent a letter to Dr. Leonard on September 15, 2003 that alluded to the possibility of an adverse determination, but failed to fulfill the requirements enumerated in 29 C.F.R. § 2560.503-1(g) for notification of an adverse benefit determination. *See* Appendix E. Dr. Leonard denies receiving the letter.

In April 2004, Educators filed an action for Declaratory Judgment and Complaint in the Court of Common Pleas of Lancaster County requesting a declaration that the health and life insurance policies of Dr. Leonard and his wife were null and void since at least December 1, 1997. Dr. Leonard filed this federal court claim for benefits in November 2004 in the United States District Court for the Eastern District of Pennsylvania. Trial in the federal case began on January 9, 2006, but was suspended because Educators had not yet rendered a decision on Dr. Leonard's claims based on its administrative review the case. On August 11, 2006, over three years after freezing Dr. Leonard's account, Educators issued a "Determination of Coverage For Benefits to Harold L. Leonard and Diane M. Leonard" which concluded that Dr. Leonard was not eligible for coverage as of December 1, 1997. *See* Appendix F. Educators determined that the recision of coverage was appropriate and, therefore, none of the outstanding medical expenses were payable.

On January 27, 2005 Educators filed a Motion to Dismiss under Federal Rule of Civil Procedure 12(b)(6). The District Court entered its Order on May 5, 2005, denying Educators' Motion to Dismiss in its entirety and certifying for review all issues raised by Dr. Leonard. On November 6, 2006, Educators filed a Motion for Summary Judgment pursuant to Federal Rule of Civil Procedure 56(c). The District Court reviewed Educators' denial of coverage to Dr. Leonard under an arbitrary and capricious standard and granted Educators' Motion for Summary Judgment on October 23, 2007.

On November 15, 2007 Dr. Leonard filed his Notice of Appeal. The decision of the Court of Appeals for the Third Circuit was entered on November 4, 2008.

REASONS FOR GRANTING THE PETITION

I. Applying a Heightened Standard of Review Where the Administrator of an ERISA Plan Fails to Exercise Discretion is Contrary to the Supreme Court's Holding in *Firestone Tire & Rubber Co. v. Bruch*.

In *Firestone Tire & Rubber Co. v. Bruch*, this Court held "that a denial of benefits challenged under § *1132(a)(1)(B)* is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 498 U.S. 101, 115 (1989).

The holding in *Firestone* was based on this Court's analysis of trust law. "Trust principles make a deferential standard of review appropriate ***when a trustee exercises discretionary powers***." *Id.* at 111 (emphasis added). "A trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee's interpretation will not be disturbed if reasonable." *Id.* As this Court explains, "one is a fiduciary to the extent he exercises *any* discretionary authority or control." *Id.* at 113. In the absence of any grant of discretionary authority to the plan administrator the applicable standard of review is *de novo*. *Id.* at 115.

Based on this Court's analysis in *Firestone*, when a plan administrator fails to exercise discretion granted to him the standard of review applied by a reviewing court must be *de novo*. Deference cannot be afforded to a plan administrator's decision in an eligibility determination where the administrator has failed to render such a decision. The failure of a plan administrator to exercise discretion leaves a reviewing court "without any decision or application of expertise to which to defer." *Nichols v. The Prudential Insurance Company of America*, 406 F.3d 90, 109 (2d Cir. 2005). A reviewing court cannot determine whether a plan administrator has abused his discretion, or whether such decision was arbitrary and capricious, where no decision exists. As the Court of Appeals for the Third Circuit explains:

> Where a trustee fails to act or to exercise his or her discretion, de novo review is appropriate because the trustee has forfeited the privilege to apply his or her discretion; it is the trustee's analysis, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer.

Gritzer v. CBS, Inc., 275 F.3d 291, 296 (3d Cir. 2002).

Review by this Court is necessary to determine the applicable standard of review where a plan administrator fails to exercise the discretion granted to him by the plan language in light of this Court's holding in *Firestone* and relevant trust law principals.

II. The United States Courts of Appeal Have Issued Conflicting Holdings with Respect to the Standard of Review to be Applied Where the Administrator of an ERISA Plan Fails to Exercise Discretion.

A. The Courts of Appeal have Issued Conflicting Holdings with Respect to the Standard of Review to be Applied Where the Administrator of an ERISA Plan Fails to Exercise Discretion in the Context of a Benefit Claim Deemed Denied by Operation of Law.

In *Nichols v. The Prudential Insurance Company of America*, the Court of Appeals for the Second Circuit considered an administrator's failure to exercise discretion in the context of a benefits claim that was deemed denied pursuant to 29 C.F.R. § 2560.503-1(h)(4) (1999). 406 F.3d 98. In *Nichols*, Prudential failed to comply with the regulatory deadlines set forth in 29 C.F.R. § 2560.503-1(h)(1)(i) which required that an administrator's decision to deny benefits be made within 60 days of the request for review. *Id.* at 106. Prior to January 1, 2001, "[i]f no decision [was] rendered by the deadline, the claim for benefits [was] deemed denied on review." *Id.* at 105. On the issue of the standard of review to be applied to the plan administrator's decision the Court of Appeals held:

> Firestone derived its holding from principles of trust law that "make a deferential standard of review appropriate when a trustee exercises discretionary powers. The Supreme Court explicitly rejected the notion that the

> authorization of some set of discretionary powers of the plan administrator rendered all actions of the administrator discretionary. In light of this reasoning, we conclude that we may give deferential review ***only to actual exercises of discretion***.

Id. at 109 (emphasis added)(internal citations omitted).

The Court of Appeals for the Tenth Circuit reached a similar holding in *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625 (10th Cir. 2003). In *Gilbertson*, the Court of Appeals considered "whether a plan administrator with discretionary authority whose delay in deciding a claim results in its being 'deemed denied' is entitled to judicial deference." *Id.* at 631. Holding that *de novo* review was appropriate in deemed denied cases the Court of Appeals explained:

> Such decisions are not exercises of discretionary power vested in the trustee, as intended by the trust instrument, because in these instances the terms of the plan and its governing regulations require that a decision be rendered within a specified time. Deference to the administrator's expertise is ***inapplicable where the administrator has failed to apply his expertise to a particular decision***.

Id. at 632 (emphasis added).

The Court of Appeals for the Third Circuit has also required that a plan administrator exercise discretion in order for a deferential standard of review to apply.

See Gritzer v. CBS, Inc., 275 F.3d 291 (3d Cir. 2002). In *Gritzer*, Appellants filed claims for pension benefits which were deemed denied when the plan administrator failed to respond within 90 days. *Id.* at 294. In fact, the plan administrator failed to respond to the merits of Appellants' claims until after litigation had already begun in the district court. *Id.* In reviewing the denial of benefits the district court applied a "heightened standard of deferential review and declined to consider the extrinsic evidence proffered by appellants in construing the relevant provisions of the plan." *Id.* at 295. The district court explained that the arbitrary and capricious standard was appropriate because the plan administrator "had unfettered discretion to interpret the Plan." *Id.* The Court of Appeals overturned the standard of review applied by the district court, holding: "Had discretion in fact been exercised in the course of denying benefits we would agree, but it was not. We, thus, conclude that the district court erred and that the denial of benefits should have received de novo review." *Id.* The Court went on to explain:

> Where a trustee fails to act or to exercise his or her discretion, de novo review is appropriate because the trustee has forfeited the privilege to apply his or her discretion; it is the trustee's ***analysis***, not his or her right to use discretion or a mere arbitrary denial, to which a court should defer.

Id. at 296 (emphasis added). The Court's holding in *Gritzer* was based on part on the Restatement (Second) of Trusts § 187 cmt. (h), which states: "If the trustee without knowledge of or inquiry into the relevant

circumstances and merely as a result of his arbitrary decision or whim exercises or fails to exercise a power, the court will interpose." *Id.*

In *Matuszak v. The Torrington Company* the Court of Appeals for the Seventh Circuit also addressed the correct standard of review to be applied where a plan administrator exercises discretion only after litigation has begun at the district court level. 927 F.3d 320 (7th Cir.1991). In *Matuszak*, Appellant employees were laid off at the time their employer announced a plant closure and relocation. *Id.* at 322. Appellants were denied plant closing benefits on grounds that they had not been "actively working . . . *on the date* of the plant closure announcement." *Id.* (emphasis contained within original). During the course of litigation in the district court, the plan administrator adopted a new position which offered benefits to laid-off employees only if they had ten years of seniority prior to their last layoff. *Id.* On the issue of the applicable standard of review the Court of Appeals found that *de novo* review was required holding that "*no* plan can provide discretion to deny benefits for reasons identified only years after the fact." *Id.* (emphasis contained within original). The Court further explained: "This Court would emasculate ERISA's disclosure requirement if it were to defer to reasons that the [plan administrator] first identified on appeal in the district court, years after the decision at issue."

The Court of Appeals for the Eight Circuit has issued conflicting decisions as to the applicable standard of review where a plan administrator fails to exercise discretion in a benefits determination. *See McGarrah*

v. Hartford Life Insurance Co., 234 F.3d 1026 (8th Cir. 2000); *Mansker v. TMG Life Insurance Co.*, 54 F.3d 1322 (8th Cir. 1995). In *Mansker*, the Court applied a *de novo* standard of review where TMG, the plant administrator, failed to "render a decision on certain issues." 54 F.3d 1322, 1328 (8th Cir. 1995). TMG had denied medical coverage on the basis of an exclusion clause in the applicable insurance policy. *Id.* at 1325. The administrator for the insured's estate subsequently filed a state court action seeking payment of medical benefits which was removed to federal district court. *Id.* On cross-motions for summary judgment the district court found that TMG was liable for the full amount of medical benefits and reduced the judgment to a total sum. *Id.* On appeal, TMG argued that the district court's determination of coverage was premature until the plan administrator had first considered the issue, and that the plan administrator's decision was to be reviewed for abuse of discretion. *Id.* at 1328. The Court of Appeals disagreed holding:

> In essence, TMG would have this court conclude . . . that, where a plan administrator or fiduciary has discretionary authority to decide issues concerning the payment of plan benefits, but fails to make a decision on such issues because coverage is being denied, the courts may not independently decide the issues even upon determination that benefits were improperly denied. We decline to adopt such a view. Rather, we hold that the consequence of TMG's ***failure to render a decision on certain issues*** concerning Mansker's medical expenses is that the

> ***district court could, as it did, decide the issues de novo.***

Id. (emphasis added).

In *McGarrah v. Hartford Life Insurance Company*, the Court of Appeals for the Eight Circuit reached a contrary decision as to the applicable standard of review. 234 F.3d 1026 (8th Cir. 2000). In *McGarrah*, Hartford terminated McGarrah's disability because "he no longer met the definition of totally disabled." *Id.* at 1029. McGarrah appealed the denial of benefits through Hartford's internal process and was advised that he would receive written notification of the results of the review. *Id.* When Hartford failed to respond to the internal appeal, McGarrah commenced an action in federal district court. *Id.* The district court, applying abuse of discretion, upheld Hartford's denial of benefits. *Id.* at 1029-1030. On appeal, McGarrah argued that Hartford was not entitled to a deferential standard of review because "a serious procedural irregularity existed." *Id.* at 1030. In particular McGarrah alleged that Hartford totally failed to respond to his appeal request. *Id.* The Court of Appeals noted that Hartford's failure to responded violated both the notice provided to McGarrah by Hartford, as well as the regulations governing appeal procedures set forth in 29 C.F.R. § 2560.503-1(h)(3). Despite these violations however, the Court of Appeals held:

> But the mere presence of a procedural irregularity is not enough to strip a plan administrator of the deferential standard of review. As we said in *Buttram, 76 F.3d at 900*,

> a claimant must also present evidence that the irregularity raises serious doubts as to whether the result reached was the product of an arbitrary decision or the plan administrator's whim.

Id. at 1031.

The Court of Appeals for the Ninth Circuit has also issued conflicting holdings as to the applicable standard of review where a plan administrator fails to exercise discretion based on a deemed denial. *See Gatti v. Reliance Standard Life Insurance Co.*, 415 F.3d 978 (9th Cir. 2005); *Jebian v. Hewlett-Packard Company Employee Benefits Organization Income Protection Plan*, 349 F.3d 1098 (9th Cir. 2003). In *Jebian*, the plan administrator failed to comply with both the time deadlines set forth by the terms of the relevant disability plan, as well as the regulatory deadlines set forth in 29 C.F.R. § 2560.503-1(h)(4). 349 F.3d at1102. As such, the disability claim was deemed denied. *Id.* at 1103. On the issue of the standard of review to be applied by the reviewing district court, the Court of Appeals held: "there is no opportunity for the ***exercise of discretion*** and the denial is usually to be review *de novo. Id.* (emphasis added). Relying on this Court's decision in *Firestone*, the Court of Appeals further explained: "[A]lthough *Firestone* directs courts to defer to the decisions of plans in which their language grants discretionary authority, ***that deference applies only when the decision is made by the body vested with discretion.***" *Id.* at 1105 (emphasis added).

Alternatively, in *Gatti v. Reliance Standard Life Insurance Company*, the Court of Appeals for the Ninth Circuit held that a violation of the time limitations set forth in 29 C.F.R. § 2560.503-1 is not a sufficient basis for *de novo* review. 415 F.3d at 983. In *Gatti*, Reliance approved Gatti for long-term disability benefits in 1993. *Id.* at 980. Reliance decided to terminate Gatti's benefits in 2000, and after an unsuccessful appeal, Gatti was given additional time to present evidence for further consideration. *Id.* at 981. In February 2001, 279 days after receiving Gatti's request for review, Reliance concluded that Gatti's submissions were insufficient to reverse its prior decision. *Id.* Reversing the district courts' *de novo* review, the Court of Appeals found that *Gatti* was distinguishable from *Jebian* on grounds that "the language of the plan being administered in *Jebian* contained the same time limits as are found in the ERISA regulation, whereas Gatti's plan with Reliance did not include time limits." *Id.* at 982. Relying on this Court's holding in *Massachusetts Mutual Life Insurance Company v. Russell*, the Court of Appeals found that the "deemed denied" language of 29 C.F.R. § 2560.503-1(h)(4) was not intended to "cut off the administrator's discretion, making *de novo* review appropriate . . . [but rather, to] provide beneficiaries with a 'final decision' from which to appeal if the administrator has not made a decision within the timelines established in the regulation." *Id.* at 983. As to whether procedural violations were sufficient to alter the standard of review, the Court held that "procedural violations of ERISA do not alter the standard of review unless those violations are so flagrant as to alter the substantive relationship between the employer and employee, thereby causing the beneficiary substantive harm." *Id.* at 985.

The Court of Appeals for the Fifth Circuit has also held that a heightened standard of review is applicable where a plan administrator fails to exercise discretion by failing to meet the regulatory deadlines. *See Southern Farm Bureau Life Insurance Company v. Moore*, 993 F.2d 98 (5th Cir. 1993). In *Southern Farm*, Mrs. Moore filed a claim for accidental death benefits on behalf of her deceased husband. *Id.* at 99. After investigation, Southern Farm denied Mrs. Moore's claim on the basis of a policy exclusion. *Id.* at 100. Southern Farm proceeded to file a declaratory judgment action "contending that the policy did not require it to pay benefits for [Mr.] Moore's death, but failed to notify [Mrs.] Moore that it was denying her claim." *Id.* Mrs. Moore filed a counterclaim for policy benefits and was permitted by the district court to introduce additional evidence regarding her husband's death. *Id.* On appeal, Southern Farm challenged the jury verdict in favor of Mrs. Moore on grounds that, *inter alia*, the district court erred by "failing to review for abuse of discretion Southern Farm Life's factual determination of the cause of [Mr.] Moore's death." *Id.* The Court of Appeals determined that Southern Farm's failure to provide Mrs. Moore's with a notice denial, resulted in the claim being deemed denied under 29 C.F.R. § 2560.503-1(h). *Id.* at 101. The Court of Appeals went on to hold:

> ***When a reviewing body fails to act*** and the claim is deemed denied on review, "a claimant's appropriate recourse is to seek review of the denial by the district court." In our view, the standard of review is no different whether the claim is actually denied or is deemed denied. The role of the district court is the same in either event, and therefore we hold that the district

> court erred in reviewing de novo the plan administrator's factual determination of the cause of Mr. Moore's death.

Id.

The holdings reached in *Gatti*, *Southern Farm* and *McGarrah* are contrary to those issued by the Courts of Appeal for the Second, Third, and Tenth Circuits. In *Aetna Health Inc. v. Davila*, this Court recognized that "[t]he purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." 542 U.S. 200, 208 (2004). Allowing a conflict to exist among the Courts of Appeal with regard to the applicable standard of review is contrary to uniform regulation of employee benefit plans. Review by this Court is necessary to resolve this conflict, and to determine the applicable standard of review where a plan administrator fails to exercise the discretion granted to him by the terms of the plan.

B. The Courts of Appeal and U.S. District Courts Have Issued Conflicting Holdings with Respect to the Standard of Review to be Applied Where the Administrator of an ERISA Plan Fails to Exercise Discretion Following the 2000 Amendments to 29 C.F.R. § 2560.503-1.

29 C.F.R. § 2560.503-1 was amended in November 2000 and became effective as of January 1, 2001. The amended version of § 2560.503-1 replaced the "deemed denied" language previous contained in subsection (h)

with current subsection (l). 29 C.F.R. § 2560.503-1(l) states:

> Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Few of the United States Courts of Appeals have revisited the issue of the applicable standard of review to be applied where a plan administrator fails to exercise discretion in making a benefits determination. Those Courts of Appeals that have considered the issue have reached conflicting holdings.

In *Bard v. Boston Shipping Association*, the Court of Appeals for the First Circuit was the first appellate court to issue a holding on the standard of review to be applied following the 2000 amendments. 471 F.3d 229 (1st Cir. 2006). In *Bard*, Appellant was terminated from his employment and subsequently applied for disability benefits on three separate occasions. *Id.* at 231. The plan administrator failed to adequately respond to all three of Appellant's applications, only rendering a final determination after Appellant had initiated a suit to recover benefits in federal district court. *Id.* at 232-235.

The district court applied an arbitrary and capricious standard of review and ultimately upheld the plan administrator's denial of benefits. *Id.* at 235. On appeal, the parties disagreed over the correct standard of review to be applied to the administrator's decision. *Id.* In its holding, the Court of Appeals declined to address the appropriate standard of review to be applied to cases brought on a "deemed exhausted" basis. *Id.* at 236. Rather, the Court held:

> Our consistent approach in ERISA cases has been to eschew automatic rules and to evaluate each case on its own. . . . Ultimately, we do not decide whether the Plan's failure to render a timely decision by itself entitles Bard to de novo review . . . Instead, in keeping with our case-by-case approach, we tailor our resolution of the issues to the unique facts presented.

Id.

Alternatively, both the Court of Appeals for the Second and Tenth Circuits have continued to apply pre-amendment precedent to ERISA cases brought under the current regulations. In *Strom v. Siegel Fenchel & Peddy P.C. Profit Sharing Plan*, the Court of Appeals for the Second Circuit upheld its prior holding in *Nichols v. The Prudential Insurance Company of America*. 497 F.3d 234 (2d Cir. 2007). In *Strom*, Appellant's claim for pension benefits was tentatively denied by the plan administrator following an internal administrative hearing. *Id.* at 240. Following a second hearing, which failed to result in a decision, Appellant

filed a complaint in federal court asking for a declaration of her rights under the applicable pension plans. *Id.* at 240-241. The district court reviewed the plan administrator's decision to determine whether it was arbitrary and capricious. *Id.* at 241. The Court of Appeals reversed, finding that the administrator's decision should have been reviewed *de novo*. *Id.* at 243. Relying on its prior holding in *Nichols*, the Court of Appeals explained:

> [T]he district court could not defer to an interpretation that the Decision never in fact made or explained. . . . In the instant case, the Plan administrators explicitly refused to decide Strom's claim, ***and such a non-decision cannot be deemed an "exercise of discretion" to which the district court might have deferred.***
>
> Because a non-existent interpretation cannot be a reasonable one, the district court erred in deferring to the Profit Plan administrators' Decision.

Id. at 243-244 (emphasis added).

In *Kellogg v. Metropolitan Life Insurance Company*, the Court of Appeals for the Tenth Circuit relied on its pre-amendment "substantial compliance" analysis in determining the applicable standard of review where a plan administrator fails to exercise discretion. 549 F.3d 818 (10th Cir. 2008). In *Kellogg*, Appellant filed a claim for life and accidental death benefits under her deceased husband's employee benefit plan. *Id.* at *6.

Appellant's claim for life insurance was granted, however her claim for accidental death benefits was ultimately denied ten months after submission. *Id.* at *7, *10. Appellant filed suit in the federal district court after the plan administrator failed to respond to Appellant's request for an administrative appeal. *Id.* at *16. On appeal, Appellant argued that the district court erred in applying a modified abuse of discretion standard of review because the administrator's "failure to ever issue a decision on her appeal results in there being 'no timely discretion act to which this court can defer.'" *Id.* at *17, *19. The Court of Appeals overturned the district court holding that a *de novo* standard of review was appropriate in reviewing the plan administrator's denial of Appellant's claims. *Id.* at *25. In reaching this holding the Court relied on the "substantial compliance" standard rule established prior to the 2000 amendments to 29 C.F.R. § 2560.503-1. *Id.* at *24. The Court declined to decide the "continuing validity of the 'substantial compliance' rule because, even assuming its continued existence, there can be little doubt that MetLife was not in 'substantial compliance' with the ERISA deadlines." *Id.* at 25.

In its decision in *Kellogg*, the Court of Appeals for the Tenth Circuit recognized that the District Court for the Western District of Oklahoma had reached a definitive conclusion on the applicable standard of review. *Id.* at *24-25 (citing *Reeves v. UNUM Life Ins. Co.*, 376 F.Supp.2d 1285 (W.D.Okla. 2005)). In *Reeves*, Plaintiff was receiving short-term disability payments, the term of which was set to expire. *Id.* at 1286. Plaintiff's claim was transferred for consideration of long-term benefits and was ultimately denied. *Id.* at 1286, 1291.

Plaintiff appealed the denial of benefits and subsequently sought judicial review when UNUM failed to issue a final decision on the appeal. *Id.* On the issue of the applicable standard of review the district court held that the pre-amendment "substantial compliance doctrine is not applicable under the revised regulations." *Id.* at 1293. The court went on to conclude that by amending 29 C.F.R. § 2560.503-1 "the Department [of Labor] rejected the notion of 'substantial compliance' and concluded that 'a decision made in the absence of the mandated procedural protections ***should not be entitled to any judicial deference.***" *Id.* at 1294 (citing 65 Fed. Reg. 70246, 70255 (Nov. 21, 2000)(emphasis added). Accordingly, the court reviewed Plaintiff's claims *de novo. Id.* at 1294.

Absent a ruling on the issue by the Court of Appeals for the Eleventh Circuit, the District Court for the Northern District of Georgia has also reviewed a plan administrator's failure to exercise discretion *de novo. See McDowell v. Standard Ins. Co.*, 555 F.Supp.2d 1361 (N.D.Ga. 2008). In *McDowell*, Plaintiff appealed an adverse disability benefit determination. *Id.* at 1364. Plaintiff was deemed to have exhausted his administrative remedies based on several regulatory violations by the plan administrator. *Id.* at 1365- 1374. As to the applicable standard of review, the district court "adopt[ed] the majority view that, 'absent substantial compliance with the deadlines, de novo review applies on the grounds that inaction ***is not a valid exercise of discretion and leaves the court without any decision or application of expertise to which to defer.***" *Id.* at 1374 (quoting *Nichols*, 406 F.3d at 109) (emphasis added).

Alternatively, district courts in the Third, Fourth, Fifth, Sixth and Ninth Circuits have applied a heightened standard of review despite a plan administrator's failure to exercise discretion following the 2000 amendments to 29 C.F.R. § 2560.503-1. In *Meyers v. GE Group Life Assurance Co.*, the United States District Court for the District of New Jersey declined to conduct a *de novo* review where the plan administrator failed to comply with the regulatory deadlines. No. 04-5488, slip op., 2006 U.S. Dist. LEXIS 13937 (D.NJ. 2006)[1]. In *Meyers*, Plaintiff was denied disability payments and subsequently filed an administrative appeal. *Id.* at *16-17. The plan administrator denied Plaintiff's claim on appeal, issuing a final determination approximately four months after the appeal was filed. *Id.* at 18. On review to the district court Plaintiff argued that the appropriate standard of review was *de novo* in light of the administrator's failure to comply with the deadlines set forth in 29 C.F.R. § 2560.503-1. *Id.* at *28. Despite the Third Circuit's earlier holding in *Gritzer*, the district court held that arbitrary and capricious review was appropriate because Plaintiff's claim had not been "deemed denied" under the amended language of the regulation. *Id.* at *31-32.

Similarly, in *Spectrum Health, Inc. v. Good Samaritan Employers Association, Inc.*, the District Court for the Western District of Michigan also declined to review Plaintiff's claims *de novo* on grounds that the

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1. Though *Meyers* is an unpublished opinion, it has been relied upon by other courts that have considered this issue. *See Hardt v. Reliance Standard Life Ins. Co.*, 494 F.Supp.2d 391, 394 (E.D.Va. 2007).

"deemed denied" language of 29 C.F.R. § 2560-503.1(h) was stricken in the 2000 amendments. ___ F.Supp.2d ___, 2008 U.S. Dist. LEXIS 100689, *17 (W.D.Mich. 2008). The district court concluded that *Nichols*, *Jebian*, and *Gilbertson* were thus inapplicable. *Id.*

In *Hardt v. Reliance Standard Life Insurance Co.*, the District Court for the Eastern District of Virginia declined to review a denial of benefits *de novo* despite the plan administrator's failure to comply with the regulatory deadlines. 494 F.Supp.2d 391 (E.D.Va. 2007). In *Hardt*, Plaintiff filed a claim for long-term disability benefits which was ultimately denied. *Id.* at 392. Plaintiff subsequently submitted an appeal to the plan administrator which was denied approximately 113 days after it was filed. *Id.* 393. On the issue of the appropriate standard of review the district court noted that "[t]here is no Fourth Circuit precedent on point, and the court has found scant discussion in other jurisdictions." *Id.* at 394. After reviewing post-amendment authorities the district court concluded that "the modified abuse of discretion standard of review is appropriate." *Id.* This holding was based on part on the fact that Plaintiff did not file her action in federal district court until after Reliance had issued its denial. *Id.* The court noted that "[h]ad Ms. Hardt filed this action *after* the 45-day period but *before* Reliance rendered its decision, the Court would then have to decide whether a deferential standard of review remains appropriate." *Id.* (emphasis contained within original).

In *Goldman v. Hartford Life & Accident Insurance Co.*, the District Court for the Eastern District of Louisiana also applied a deferential standard of review

where the plan administrator failed to respond to Plaintiff's request for administrative appeal. 417 F.Supp.2d 788 (E.D.La. 2006). Regarding the standard of review, the district court acknowledged that Hartford did not timely decide Plaintiff's appeal. *Id.* at 796. The district court conducted an extensive review of the authorities issued under both pre- and post-amendment 29 C.F.R. § 2560.503-1. *Id.* at 798-806. This review included the Department of Labor's comments it its notice of final regulation issued, 65 Fed. Reg. 70246 (November 21, 2000). *Id.* at 803. Despite the Department's explicit instruction that "a decision made in the absence of the mandated procedural protections ***should not be entitled to any judicial deference***," the district court held:

> Although this change cements the argument that untimely benefits decisions should presumptively be subject to *de novo* review, the Court does not believe that the Fifth Circuit would adopt the Department of Labor's position and apply *de novo* review in all cases. . . . The Court therefore holds that the Fifth Circuit would continue to look to the record to determine whether a claims decision that does not comply with *section 2560.503-1* is entitled to any judicial deference. The Court also predicts that the Fifth Circuit would adopt the exceptions to *de novo* review recognized by other circuits in cases such as *McGarrah*, *Finley*, and *Gatti*.

Id. at 804-805. The district court proceeded to review Hartford's determination for abuse of discretion. *Id.* at 805.

Based on the Ninth Circuit's pre-amendment holdings in *Gatti* and *Jebian*, the District Court for the District of Arizona has also refused to apply a *de novo* standard of review to a plan administrator's failure to exercise discretion. *See Peterson v. Federal Express Corp. Long Term Disability Plan*, __ F.Supp.2d ___, 2006 U.S. Dist. LEXIS 34343 (D.Ariz. 2006). In *Peterson*, Plaintiff's long-term disability benefits were terminated by the plan administrator and Plaintiff timely appealed the adverse determination. *Id.* at *2. The plan administrator denied Plaintiff's appeal, but only notified Plaintiff of the denial four months after making the determination. *Id.* at *3. Plaintiff subsequently filed for review in federal district court, arguing that the court should apply a *de novo* standard of review based on the Ninth Circuit's holding in *Jebian*. *Id.* at *3, *11. After reviewing both *Jebian* and *Gatti*, the district court determined that the facts at issue were consistent with *Gatti*, and therefore declined to review Plaintiff's claim *de novo*. *Id.* at *19. In conducting its analysis the district court questioned whether the rationale set forth in both *Jebian* and *Gatti* remained valid in light of the 2000 amendments to 29 C.F.R. § 2560.503-1. *Id.* at 17. The court ultimately concluded:

> *Gatti* and *Jebian* demonstrate that it is unlikely that the Ninth Circuit would interpret *29 C.F.R. § 2560.503-1(l)* as requiring de novo review every time a plan administrator violates ERISA, no matter how inconsequential the violation. . . . Therefore, the Ninth Circuit would most likely not interpret *C.F.R.* § 2560.503-1(l) as requiring de novo review for every ERISA violation.

> However, the question remains whether *Jebian's* "substantial compliance" or *Gatti's* requirement that the violations be flagrant and affect the substantive relationship between employer and employee should be the governing standard.

Id. at *19.

Such conflict between the circuits is contrary to this Court's holding in *Aetna* that "[t]he purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." 542 U.S. at 208. Review by this Court is necessary to resolve this conflict, and to determine the applicable standard of review where a plan administrator fails to exercise the discretion granted to him by the terms of the plan.

III. Applying a Heightened Standard of Review Where the Administrator of an ERISA Plan Fails to Exercise Discretion is Contrary to the Principles of ERISA.

Congress enacted ERISA "to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b). This purpose is to be achieved "by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts." 29 U.S.C. § 1001(b). The Court of Appeals for

the Fifth Circuit describes ERISA's primary objective as "[s]afeguarding the well-being and security of working men and women and to appraise them of their rights and obligations under any employee benefit plan." *Meredith v. Time Ins. Co.*, 980 F.2d 352, 358 (5th Cir. 1993).

The protection of employee benefit participants is achieved through several statutory and regulatory disclosure requirements. 29 U.S.C. § 1133 establishes that:

> [E]very employee benefit plan shall—
>
> > (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting for the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
> >
> > (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 C.F.R. § 2560.503-1 is the regulation under which the provisions of 29 U.S.C. § 1133 are carried out. Subsection (f) of the regulation requires that plan administrators provide written notice of an adverse benefit determination "no later than 90 days after receipt of the claim by the plan." 29 C.F.R. § 2560.503-1(f). Subsection (h) of the regulation requires a plan

administrator to "establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination." 29 C.F.R. § 2560.503-1(h). Finally, subsection (l) mandates that as a result of an administrator's failure to comply with the claims procedures set forth in the regulation, "a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act . . . " 29 C.F.R. § 2560.503-1(l).

A plan administrator's failure to exercise discretion is contrary to the purposes and principles of ERISA as expressed by the established statutory and regulatory disclosure requirements. Failure to render a decision as to benefit eligibility deprives a participant of his right to notification and a full and fair review of the decision as mandated by 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1. Here, Dr. Leonard was allegedly informed in September 2003 of the ***possibility*** of an adverse determination with respect to medical claims submitted to Educators for payment under the terms of his policy. *See* Appendix D. By its very terms, this notification did not constitute a denial of Dr. Leonard's claims and failed to conform to the requirements set forth in 29 C.F.R. § 2560.503-1(g). In April 2004, Educators filed a declaratory judgment action in the Court of Common Pleas of Lancaster County asking the court to make the determination as to Dr. Leonard's eligibility for benefits. Dr. Leonard only received written notice of the adverse benefit determination by letter on August 11, 2006,

nearly two years after he filed a claim for benefits in the United States District Court for the Eastern District of Pennsylvania. *See* Appendix E.

Despite Educator's failure to both exercise discretion as to Dr. Leonard's eligibility and comply with the statutory and regulatory requirements of ERISA, the district court reviewed Educator's determination under a heightened arbitrary and capricious standard of review. As a result, Dr. Leonard was deprived of any meaningful opportunity for a full and fair review of the determination as granted to him by the applicable statutes and regulations. In preparing their August 11, 2006 determination, Educator's relied on information it received in the discovery and trial preparation processes. Alternatively, the district court's failure to apply a *de novo* standard of review prohibited Dr. Leonard from effectively rebutting the August 11, 2006 determination. Accordingly, Dr. Leonard's interests as a plan participant were not protected as mandated by 29 U.S.C. § 1001(b).

Additionally, application of a heightened standard of review where an administrator fails to exercise discretion directly contravenes the Department of Labor's intention in amending 29 C.F.R. § 2560.503-1(l). The Department has expressly stated that its "intentions in including this provision in the proposal were to clarify that the procedural minimums of the regulation are essential to procedural fairness and that ***a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference***." 65. Fed. Reg. 70246, 70255 (Nov. 21, 2000) (emphasis added). Review by this Court is necessary to

determine the applicable standard of review to be applied to a plan administrator's failure to exercise discretion, and to resolve this apparent conflict with the expressed purpose of ERISA and its accompanying regulations.

CONCLUSION

For all the foregoing reasons, petitioners respectfully request that the Supreme Court grant review of this matter.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT FILED NOVEMBER 4, 2008

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 07-4370

HAROLD L. LEONARD
d/b/a THE LEONARD CLINIC OF CHIROPRACTIC,

Appellant

v.

EDUCATORS MUTUAL LIFE
INSURANCE COMPANY.

Before: McKEE, NYGAARD, and MICHEL,* Circuit Judges.

OPINION OF THE COURT

NYGAARD, Circuit Judge.

The issue before the District Court was whether Appellee, Educators Mutual Life, acted arbitrarily and capriciously in determining that Appellant, Harold L. Leonard, was not eligible for benefits within the meaning of the policy Leonard held with Educators. The District

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* Honorable Paul R. Michel, Chief Judge for the United States Court of Appeals for the Federal Circuit, sitting by designation.

Court granted summary judgment for Educators. Leonard appeals, raising four issues. We will affirm.

The facts and procedures are well known to the parties and are extensively discussed in the District Court's comprehensive opinion. Hence, we will only briefly reiterate them here. Appellee, Educators, concluded that Leonard was ineligible for coverage, giving four reasons to support its decision: First, because his chiropractic clinic was no longer in operation, as was required by the policy; second, because there were not at least two employees as required by a group policy; third, because Leonard was not working for compensation at least 30 hours per week; and, fourth, and quite significantly, because Leonard had consistently misrepresented material facts.

The District Court properly concluded that the language of the plan gave the administrator discretionary authority. Hence, it reviewed Educators' decision to determine if it was arbitrary or capricious. *See Abnathya v. Hoffman-La Roche, Inc.*, 2 F.3d 40 (3d Cir.1993). Under this standard, a court must defer to the administrator unless the administrator's decision was without reason and unsupported by substantial evidence or erroneous as a matter of law. The record indicates that the District Court applied the appropriate standard, comprehensively examined each of the reasons given by Educators as to why they denied Leonard coverage, and determined that Educators' denial was reasonable and supported by sufficient facts. Hence, and essentially for the reasons given by the District Court in its memorandum and order dated the 23rd day of October, 2007, we will affirm.

APPENDIX B — MEMORANDUM AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA FILED OCTOBER 23, 2007

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 04-5310

HAROLD L. LEONARD,
d/b/a The Leonard Clinic of Chiropractic,

Plaintiff,

v.

EDUCATORS MUTUAL LIFE INSURANCE CO.,

Defendant.

Memorandum and Order

YOHN, J. October ___, 2007

Plaintiff Harold L. Leonard ("Dr.Leonard"), doing business as The Leonard Clinic of Chiropractic ("the Clinic"),[1] brought suit against defendant Educators Mutual Life Insurance Co. ("Educators") under the Employee Retirement Income Security Act of 1974,

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1. The Clinic is listed as a plaintiff in the matter, but is not registered as a fictitious name; therefore, that entity may not bring suit.

29 U.S.C. § 1001 *et seq.* ("ERISA") to recover unpaid medical benefits owed under a group insurance policy. Educators brought a motion for summary judgment on plaintiff's complaint pursuant to Federal Rule of Civil Procedure 56(c). Upon consideration of the motion for summary judgment, the court raised the issue of federal subject matter jurisdiction *sua sponte,* as it appeared to be lacking, and requested supplemental briefs from the parties on that issue.[2] For the reasons that follow, I hold that the plan at issue is governed by ERISA, but I will grant Educators's motion for summary judgment as to plaintiff's claim for benefits.

I. Background

A. Factual History[3]

Educators is a mutual life insurance company located in Pennsylvania, which now operates by the name of Eastern Life & Health Insurance Co. (Pl.Ex. 38 ("Agreed Facts") ¶ 2; Def. Summ. J. Mem. 1 n. 1.) In 1983, Dr. Leonard opened the Clinic at 1285 Manheim Pike, Lancaster, Pennsylvania, 17603. (Agreed Facts

2. "A federal court has the obligation to address a question of subject matter jurisdiction *sua sponte.*" *Meritcare Inc. v. St. Paul Mercury Ins. Co.*, 166 F.3d 214, 217 (3d Cir.1999).

3. There are few disputed facts in this case. The following account contains the admitted facts and plaintiff's evidence because when deciding a motion for summary judgment courts must view all facts and inferences in the light most favorable to the non-moving party. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986).

¶ 4.) In July of 1990, the Clinic applied for group medical and life insurance coverage for its employees through Educators. (Agreed Facts ¶ 5; Def. Ex. 3.) At that time, Dr. Leonard's insurance agent was John C. Snyder (Agreed Facts ¶ 15); however, because the Clinic was considered a very small client, Snyder's assistant was primarily responsible for dealing with the Clinic (Def. Ex. 29 ("Synder Dep.") 7). In the application, the address of the clinic was reported as 1285 Manheim Pike, and three employees were to be covered by the policy. (Def.Ex. 3.) Educators did not offer or issue individual medical insurance plans. (Synder Dep. 32.)

Educators issued a group medical insurance policy and group life insurance coverage for Dr. Leonard and the Clinic's employees, including Dr. Leonard's wife, Diane Leonard. (Agreed Facts ¶ 5.) Educators assigned the Clinic group insurance policy number 8098. (Agreed Facts ¶ 6.) In order to qualify for group coverage, Educators required the Clinic to have at least three employees, (Def. Ex. 8; Def. Ex 30 ("Rankin[4] Dep.") 11), working at least thirty hours per week and compensated for their services, (Def. Summ. J. Mem 2). After 1996, the Clinic was only required to have two employees. (Rankin Dep. 11.) In the Clinic's application dated December 2, 1997, there were reported to be a total of two eligible employees. (Pl.Ex. 8.) Educators reviewed the policies on an annual basis and notified customers of new prices for coverage. (Snyder Dep. 28.) Dr.

4. Kimberly A. Rankin is Vice President and Corporate Secretary for Educators.

Leonard paid the monthly invoices for health and life insurance to Educators. (Agreed Facts ¶ 14.)

In the fall of 1993, Dr. Leonard decided to resume his education and seek a degree in physical therapy from the University of Delaware. (Agreed Facts ¶ 11.) Dr. Leonard sold the Clinic to another chiropractor, Dr. Charles Czop, who took over the Clinic on January 1, 1994. (Agreed Facts ¶ 11; Def. Ex. 26 ("Dr. Leonard Dep.") 28.) Dr. Leonard was not an employee of Dr. Czop, but he continued to perform some services at the Clinic, including consultation with Dr. Czop and various insurance companies. (Pl.Ex. 35 ("Dr. Leonard Aff.") ¶ 2; Dr. Leonard Dep. 33; Pl.Ex. 27 ("Diane Leonard Dep.") 10.) Dr. Leonard also maintained a lock box for mail at the Clinic through March of 1999. (Dr. Leonard Aff. ¶ 2.) Dr. Leonard did not inform Educators of the fact that he had sold his Clinic or that the clinic at the site was being operated by Dr. Czop. (Def.Summ. J. Mem.3.) During Dr. Leonard's time at the University of Delaware, through February of 1999, the Leonards maintained a residence at 1364 Country Club Drive, Lancaster, Pennsylvania. (Agreed Facts ¶ 13.)

On May 25, 1995, pursuant to Dr. Leonard's request, Dr. Leonard's Pennsylvania chiropractic license was placed on inactive status. (Pl.Ex. 9.) According to Educators, it was not aware that Dr. Leonard was not licensed to practice in Pennsylvania at that time (Def.Summ. J. Mem.4) and Dr. Leonard has not disputed that fact. In September of 1995, Dr. Leonard opened a chiropractic clinic in Ellicott City, Maryland, and the

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Leonards maintained a second residence in a condominium in Ellicott City, Maryland. (Agreed Facts ¶¶ 10, 13.) Dr. Leonard, Diane Leonard, and several other employees operated the Ellicott City clinic, but it was affiliated with a large chiropractic organization under the name Yalich Clinic of Ellicott City. (Agreed Facts ¶ 10.) In late summer of 1997, Dr. Leonard ceased his affiliation with the Yalich Clinic and began operating as the Back & Neck Pain Treatment Center of Ellicott City; this clinic was a sole proprietorship. (Agreed Facts ¶ 11.) Diane Leonard provided services to Dr. Leonard as an office manager for the Back & Neck Pain Treatment Center of Ellicott City, although she was not compensated for those services. (Diane Leonard Dep. 16-18.) After the Leonards separated in June 1997, Diane Leonard ceased providing any services to Dr. Leonard's clinic in Maryland. (Diane Leonard Dep. 8.)

According to Educators, Dr. Leonard did not notify it that he was practicing in Ellicott City, Maryland (Def.Summ. J. Mem.4); however, while Dr. Leonard practiced in Maryland, he made payments to Educators from his Maryland checking account, which checks stated his Maryland address (Leonard Aff. ¶ 2). Educators also issued several Explanations of Benefits ("EOBs") to Dr. Leonard at his Ellicott City address and corresponded with Dr. Leonard at that address. (Pl.Ex. 39.)

The Clinic submitted an application for life insurance and comprehensive major medical insurance dated October 30, 1997, with a desired effectiveness date of

October 1, 1997. (Def.Ex. 11.) The reason for the application was to change the Clinic's medical insurance plan from an indemnity plan to a preferred provider organization ("PPO") plan because, according to Snyder's recollection, Educators came out with a new policy series that was likely advantageous for the Clinic's employees. (Synder Dep. 14.) Snyder prepared and signed the application (Snyder Dep. 14-15; Def. Ex. 11), and Dr. Leonard signed the application (Leonard Dep. 122; Def. Ex. 11). The Clinic's application stated the name of the business as "Leonard Chiropractic Clinic" and the address of the business as "1285 Manheim Pike, Lancaster, PA, 17601." (Def.Ex. 11.) Employee application forms were submitted on behalf of Dr. and Diane Leonard. (Def.Exs.12, 13.) Dr. Leonard's application stated that he worked thirty hours per week as a "Chiropractor / Consultant." (Def.Ex. 12.) The application stated, among other things, above the signature line, "I represent that I am actively and regularly working at least 30 hours a week for the employer named above . . ." (*Id.*) Diane Leonard's application stated that she worked thirty-five hours per week and that her job duties included office management and marketing. (Def.Ex. 13.) Diane Leonard denies preparing or signing this form. (Diane Leonard Dep. 106-08). Dr. Leonard admits preparing a portion of this form, but stated that he did not sign it on Diane Leonard's behalf. (Dr. Leonard Dep. 140-41.) It is undisputed that by this time Diane Leonard was no longer working for Dr. Leonard at any location and that they were, in fact, separated. Snyder prepared a follow-up application for insurance, dated December 2, 1997,

with a desired effectiveness date of December 1, 1997, which was submitted to Educators. (Def.Ex. 14.)

Educators issued a new group PPO policy to Dr. Leonard and the Clinic with an effective date of July 1, 1998. (Agreed Facts ¶ 19.) A booklet entitled "Your Group Medical Insurance Benefits," which included a Master Certificate effective July 1, 1998, was also issued. (Def. Ex. 2; Pl.Ex. 13.) In a section entitled "Eligible Employee," this group policy stated:

You must be a U.S. citizen and performing all of the duties of **your** job with a **covered employer** on a full-time basis. This may be at either:

- the **covered employer's** normal place of employment; or

- at some other place to which the regular business operations of the **covered employer** require **you** to travel.

To be "full-time" **you** must:

- regularly work for the **covered employer** at least 30 hours per week; and

- be on the regular payroll of the **covered employer** for that work.

(Pl.Ex. 13 at 32; Def. Ex. 2 at 32 (emphasis in original).) In another section, entitled "Termination of your medical coverage," the policy stated as follows:

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Your medical coverage will terminate at 11:59 p.m. on the earlier of the following:

- the date the **plan** terminates; or
- the date **your** employer ceases to be a **covered employer;** or
- the day concurrent with or following: (a) the date **you** are no longer a member of an eligible class; or (b) the date **you** are no longer **an active employee,** except as provided under the Continuation of Coverage Provision, below; or (c) the date **you** retire.

(Pl.Ex. 13 at 6; Def. Ex. 2 at 6 (emphasis in original).) The July 1, 1998 group policy also included the following General Provision:

> Statements made by you.
>
> All statements made by you, in the absence of fraud, are representations and not warranties. A statement made by you may be used to contest your entitlement to coverage only if: (a) it is part of a written application; and (b) a copy of the application has been given to you or your beneficiary; and (c) the coverage for which the statement was made has been in effect for less than two years during your lifetime.

(Agreed Facts ¶ 20; *see also* Pl.Ex. 13 at 28.; Def. Ex. 2 at 28.)

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Unlike previous times the Leonards had separated, two months following their separation in June 1997, Diane Leonard filed for divorce from Dr. Leonard. (Leonard Aff. ¶ 13.) Health coverage for Diane Leonard was an issue in the proceedings, and on December 5, 1997, the Court of Common Pleas ordered Dr. Leonard to provide medical insurance coverage for Diane Leonard. (Agreed Facts ¶ 25; Pl.Ex. 18.) In August of 1999, Diane Leonard was diagnosed with cancer. (Agreed Facts ¶ 24.) According to Dr. Leonard, because Diane Leonard insisted on having an Educators insurance policy, the court ordered him to maintain the Educators' policy, even though he would have preferred to change to Blue Cross / Blue Shield or Health America. (Dr. Leonard Aff. ¶ 29.) He specifically avers that the monthly premium he paid to Educators was over twice the cost of a Blue Cross / Blue Shield Policy. (Dr. Leonard Aff. ¶ 29.)

Due to worsening orthopedic problems, Dr. Leonard discontinued treating patients in the fall of 1998. (Agreed Facts ¶ 21.) As a consequence of his disability, another chiropractor worked at Dr. Leonard's Ellicott City clinic approximately three days a week, until June 1999 when the Ellicott City office was closed. (Agreed Facts ¶ 23.) Although he no longer treated patients, Dr. Leonard maintained HMO contracts and continued to consult with patients through the end of 2003. (Dr. Leonard Aff. ¶ 17-19.)

On December 21, 1998, Dr. Leonard began using the services of Murray Insurance Associates, Inc. ("Murray

Insurance"), and on January 4, 1999, Educators advised Snyder of Dr. Leonard's request to recognize a new broker of record and so recognized Murray Insurance. (Agreed Facts ¶¶ 16-17.) The next month, in February of 1999, the Leonards sold their residence in Lancaster and the mailbox at 1285 Manheim Pike was discontinued. (Agreed Facts ¶ 30.) When Paul Ronvak, the Clinic's insurance agent through Murray Insurance, was first assigned the Clinic as a client he attempted to make contact with Dr. Leonard by going to the Clinic's address at 1285 Manheim Pike; however, there was no longer a chiropractic clinic located there. (Ronvak Dep. 43-44.) Ronvak then had a conversation with a representative from Educators, whom he told that he could not find a location for the Clinic. (Ronvak Dep. 44.) At some point, that representative told Ronvak that there may be a post office box and an Ellicott City address, and that she would get back to him. (Ronvak Dep. 45.)

Also sometime in 1999, Dr. Leonard received a letter from Educators stating that it would not be renewing the Clinic's policy because he was located in Maryland. (Dr. Leonard Dep. 159.) Dr. Leonard believed that the decision not to renew was prompted by Diane Leonard's cancer diagnosis rather than his location in Maryland. (Dr. Leonard Dep. 160.) Educators referred him to his insurance agent, Murray Insurance, and Rovnak advised Dr. Leonard that it would be better to have a Pennsylvania address, so Dr. Leonard obtained one. (Leonard Dep. 160, 165.) Sometime in August or September of 1999, Dr. Leonard signed a "Location Verification Document for Leonard Clinic of

Chiropractic" stating that the Clinic's primary location was 1285 Manheim Pike, Lancaster, Pennsylvania,17601, and the Clinic's second location was in Ellicott City; he added a handwritten note requesting mail be sent to "P.O. Box 422, Brownstone, PA 17508"; this document stated "cc: Educators Mutual Life Insurance Company." (Ex. 19 of Leonard Dep.) In October of 1999, Dr. Leonard wrote to Educators requesting "to change the billing and mailing address to: P.O. Box 422[,] Brownstone, PA 17508." (Pl.Ex. 17 of Leonard Dep.) Based on verbal conversations with Educators, Rovnak believed that having two locations was permissible as long as the two locations were within driving distance. (Def. Ex. 28 ("Rovnak Dep.") 95-96.)

In February 2002, Educators announced that it was exiting the group health insurance market. (Rankin Dep. 7.) The date of termination for the Clinic's policy was July 31, 2003. (Pl.Ex. 25.)

The Leonards submitted several claims for benefits to Educators.[5] In May of 2003, Dr. Leonard was seen at Deborah Heart & Lung Center for cardiac problems and, after initial tests, Dr. Leonard was hospitalized on an emergency basis for heart bypass surgery. (Agreed Facts ¶ 28.) On July 14, 2003, an Educators employee

5. Educators states that on behalf of Dr. Leonard, Educators has paid since January 1, 1998 the amount of $8,165.31 and has received charges for, but has not paid, $201,851.05. Since January 1, 1998, on behalf of Diane Leonard, Educators states that it has paid $135,573.88 and has received charges for, but has not paid, $23,543.00. (Pl.Ex. 32.)

wrote an email stating "I need to stop all claim payments for Harold Leonard . . . and his wife Diane" and that she had "turned the file over to [Rankin] for review." (Pl.Ex. 28.) In August of 2003, Educators "froze" the Clinic's account and stopped making all claims payments. (Rankin Dep. 69, 88-89; Pl.Ex. 27.) Educators, through counsel, sent a letter dated September 15, 2003 to Dr. and Diane Leonard stating that "Educators has information indicating that, for several years, the Clinic has not been an active employer business operation, and that neither of you have been 'actively at work' for the Clinic." (Ex. A of Def. Reply.) The letter further requested specific documents and information from the Leonards and stated that Educators would not process outstanding claims until the investigation could be completed. (Ex. A of Def. Reply.) According to counsel for Educators, that information was never received. (Hr'g, Jan. 9, 2006 10:8-23, 11:19-24) and Dr. Leonard does not assert otherwise.

B. Procedural History

On April 7, 2004, Educators filed suit in the Court of Common Pleas of Lancaster County, Pennsylvania against Dr. Leonard, Diane Leonard, and the Clinic. The complaint seeks a declaratory judgment that the Educators policy with the Clinic is null and void as of December 1, 1997, and consequently, that it is not responsible for the Leonards' outstanding medical bills. On June 30, 2004, plaintiff filed a counterclaim against Educators, alleging breach of contract and violations of ERISA and Pennsylvania's Unfair Insurance Practices

Act, 40 Pa. Cons.Stat. § 1171.1 *et seq.* In their ERISA claim, plaintiffs sought to recover unpaid medical benefits and attorneys' fees pursuant to 29 U.S.C. § 1132(a)(1)(B)[6] and § 1132(g)(1).[7,8] Six months later, on December 10, 2004, plaintiffs filed the instant suit. The complaint originally brought two claims under ERISA—a claim for benefits and breach of fiduciary duty. Educators filed an answer, wherein it asserted a counterclaim seeking a declaration that the Leonards' policy is null and void since at least December 1, 1997 due to misrepresentations and judgment in the amount of $143,739.19, less premiums and fees paid by plaintiff. (Def. Answer ¶ 60.)

On January 27, 2005, Educators filed a motion to dismiss the federal complaint pursuant to Federal Rule of Civil Procedure 12(b) (6) requesting the court decline to exercise jurisdiction over the case and instead defer to the parallel state court proceedings pursuant to the *Colorado River* abstention doctrine. That motion was

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6. This section provides that "a participant or beneficiary" of an "employee benefit plan" may bring a civil action "to recover benefits due to him under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

7. This provision states that in any action arising under ERISA, "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." 29 U.S.C. § 1132(g)(1).

8. ERISA provides that state courts have concurrent jurisdiction with United States district courts over actions arising under § 1132(a)(1)(B). 29 U.S.C. § 1132(e)(1).

denied on May 5, 2005.[9] The action was scheduled for a non-jury trial on January 9, 2006. At that time, counsel presented argument and certain exhibits were entered into evidence. However, during the proceedings, it became apparent that it would be preferable to proceed once there had been an initial administrative review. Therefore, by agreement of the parties, the case was placed in civil suspense pending completion of the review of the Leonards' claim for benefits. (Order, Jan. 10, 2006.) The plaintiff's breach of fiduciary duty claim was dismissed by agreement of counsel. (Order, Jan. 9, 2006.)

On August 11, 2006, Educators issued a determination letter stating that the Leonards were ineligible for coverage as of December 1, 1997, and rescinding coverage as of that date. (Def.'s Ex. 25.) Educators ultimately determined that the Clinic did not have two eligible employees, as "neither Dr. or Diane Leonard was working at least thirty hours per week in the operation of the clinic's business, receiving full compensation for those services," and Dr. Leonard had "consistently misrepresented material facts." (*Id.*) Educators also concluded that Dr. Leonard was motivated into "fraudulently obtaining from Educators"

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9. The court denied the motion on two grounds: the breach of fiduciary claim fell within exclusive federal jurisdiction, thus the state and federal actions were not truly parallel, and there were not "exceptional" circumstances warranting abstention even if the proceedings were parallel. *See Leonard v. Educators Mut. Life Ins. Co.*, 2005 U.S. Dist. LEXIS 7941 (E.D.Pa. May 5, 2005).

group coverage because pursuant to his divorce proceedings, he was required to purchase individual coverage for Diane Leonard, which would have been "substantially more expensive." (*Id.*) Educators filed the instant motion for summary judgment on November 6, 2006, requesting the court enter judgment in its favor "on all claims asserted by Plaintiffs"; plaintiff filed a response to which Educators filed a reply.

In considering Educators's motion for summary judgment on the complaint, the court raised a question as to whether there existed federal question subject matter jurisdiction, pursuant to 28 U.S.C. § 1331. (Order, June 27, 2007.) The parties have now submitted supplemental briefing on the issue of jurisdiction. Plaintiff asserts that the court should retain federal question subject matter jurisdiction because the health insurance policy was governed by ERISA at the time it was created and changing the status of said plan would be contrary to the purposes of ERISA, regulations issued by the Department of Labor, and the parties' intentions. Educators argues that under the applicable case law, the plan at issue is plainly not covered by ERISA.

II. Subject Matter Jurisdiction

A. ERISA Background

ERISA covers two kinds of employee benefit plans: employee welfare benefit plans and employee pension benefit plans. 29 U.S.C. § 1002. Collectively, they are

called employee benefit plans. § 1002(3). An employee welfare benefit plan is defined as

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . .

§ 1002(1). A pension plan is defined as

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program—(i) provided retirement income to employees, or (ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond, . . .

§ 1002(2).

Appendix B

The Secretary of Labor, charged with "prescribing such regulations as he [or she] finds necessary or appropriate to carry out the provisions of this title," § 1135, has issued regulations clarifying the definitions contained in § 1002. *See* 29 C.F.R. 2510.3-3 ("This section clarifies the definition . . . of the term 'employee benefit plan' for purposes of title I of the Act and this chapter . . . to determine whether they constitute employee benefit plans . . . ."). The regulations state:

> (c) Employees. For purposes of this section:
>
> (1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and
>
> (2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.

Id. The Supreme Court has clarified that these regulations apply to the threshold issue of whether an ERISA plan exists, "not to the statutory definitions of participant and beneficiary." *Yates v. Hendon*, 541 U.S. 1, 20, 124 S.Ct. 1330, 158 L.Ed.2d 40 (2004).

Under paragraph (a)(1)(B) of section 1132 of ERISA, a "participant or beneficiary" may bring a civil action "to recover benefits due to him [or her] under the terms

of his [or her] plan, to enforce his [or her] rights under the terms of the plan, or to clarify his [or her] rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Federal district courts and state courts have concurrent jurisdiction over actions brought under that paragraph. § 1132(e)(1).

B. Whether the Leonards' Plan is Covered by ERISA

The Third Circuit has spoken directly to the structure of the plan at issue in this case as it currently exists and has determined that it does not come within the scope of ERISA. In *Matinchek v. John Alden Life Ins. Co.*, 93 F.3d 96 (3d Cir.1996), Matinchek and his wife, sole owners of a funeral home, had enrolled in a group health insurance plan. *Id.* at 102. Matinchek filed suit against the insurance company seeking to recover benefits provided by the policy. *Id.* at 99. From the outset of the litigation, both the parties and the district court assumed that the dispute was governed by ERISA and that ERISA was the source of the court's federal question jurisdiction. *Id.* The Third Circuit found that the ERISA statutory scheme did not address whether an insurance plan covering only a business owner and his or her immediate family members can qualify as an employee welfare benefit plan. *Id.* at 100. The court noted that Department of Labor regulations exclude from ERISA's coverage those plans that do not cover any employees and its rule that "an individual and his or her spouse [are] not . . . deemed to be employees with respect to a trade or business . . . which is wholly owned by the individual or by the individual and his or her

spouse." *Id.* (quoting 29 C.F.R. § 2510.3-3(c)(1)). In light of these regulations, the goals of ERISA, and common sense understanding of the terms "employer" and "employee," the court held "that an insurance coverage plan covering only a sole business owner and his or her [spouse] cannot qualify as an employee welfare benefit plan covered by ERISA." *Id.* at 101; *see also Leckey v. Stefano*, 263 F.3d 267, 270 (3d Cir.2001) (reiterating and explaining the holding of *Matinchek*). In *Yates*, the Supreme Court recently confirmed this holding, concluding: "Plans that cover only sole owners or partners and their spouses, the regulation instructs, fall outside Title I's domain. Plans covering working owners and their nonowner employees, on the other hand, fall entirely within ERISA's compass." *Yates*, 541 U.S. at 21 (internal citations and footnotes omitted).[10] Accordingly, as of the date from which Educators contends the policy should be rescinded, it would not have been deemed an ERISA-covered employee benefit plan as it was only a plan covering a sole business owner and his spouse.

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10. Portions of the Third Circuit's discussion in *Matinchek* are arguably overruled by the Supreme Court's decision in *Yates*, 541 U.S. 1, 124 S.Ct. 1330, 158 L.Ed.2d 40. For instance, the Third Circuit stated, "Congress clearly intended 'employer' and 'employee' to be mutually exclusive definitions under ERISA." *Matinchek*, 93 F.3d at 101. In *Yates*, the Court held that working owners could be participants in employee benefit plans where there were non-employer participants in the plan. *Yates*, 541 U.S. at 16 (stating "a working owner can wear two hats, as an employer and employee"). However, *Matinchek*'s relevant holding that a plan only covering a sole owner and his or her spouse is not an ERISA plan remains intact. *Yates*, 541 U.S. at 21.

C. Whether a Plan May Lose its ERISA Status

Plaintiff argues that because the plan at issue was covered by ERISA when it was first created—as it covered at least one additional employee—it should not lose its status due to employee attrition where, as here, Dr. Leonard's stated reason for not having any additional employees was due to his health problems. Educators argues that the question of whether a plan may lose ERISA status due to employee attrition is not necessary for the court to address as the Leonards' policy renewed annually and the Leonards were the only plan participants for several years prior to the point at which plaintiff seeks benefits.

As described above, the Supreme Court recently took up the question of whether a "working owner of a business" may "qualify as a 'participant' in a pension plan covered by [ERISA]." *Yates*, 541 U.S. at 6. The Court held that where "the plan covers one or more employees other than the business owner and his or her spouse, the working owner may participate on equal terms with other plan participants." *Id.* Therefore, at the inception of the Leonards' plan, the plan was governed by ERISA as it included another employee in addition to Dr. and Diane Leonard. *See id.; Leckey*, 263 F.3d at 272 (finding plans governed by ERISA as each had a least one employee-participant). Whether a plan may lose its ERISA status due to employee attrition presents a substantial question, which the Third Circuit has yet to address. *See Leckey*, 263 F.3d at 270 ("We need not decide when a plan's ERISA status ought to be

determined or whether a plan may lose its ERISA status by attrition as we conclude that even at the time of the alleged distributions, both plans were governed by ERISA.").

The Ninth Circuit[11] has resolved that for purposes of an employee welfare benefit plan—as opposed to a pension plan—whether a plan is ERISA qualified should be "determined after considering the purpose of the plan *when it was established* or as it is maintained." *In re Stern*, 345 F.3d 1036, 1041 (9th Cir.2003), *cert. denied*, 541 U.S. 936 (2004) (emphasis added) (citing *Peterson v. Am. Life & Health Ins. Co.*, 48 F.3d 404, 407-08 (9th Cir.1995), *cert. denied*, 516 U.S. 942, 116 S.Ct. 377, 133 L.Ed.2d 301 (1995)). In *In re Stern*, the plaintiff argued that ERISA applied to the pension plan at issue in order to exclude the plan's assets from the bankruptcy estate. *In re Stern*, 345 F.3d at 1040-41. However, at the time the plaintiff filed his petition for bankruptcy, the only participant in the plan was the plaintiff, as a working owner, and his spouse, as he had married the only other employee covered by the pension plan. *Id.* at 1039, 1041. The district court applied the

11. While I certainly am not bound by a decision emanating from the Ninth Circuit, its persuasiveness is more weighty when deciding ERISA-related issues. The Third Circuit has noted "that, in the context of ERISA, maintaining uniformity of decisions is an important consideration" and though "certainly not bound to create uniform common law rules, we must attempt, to the extent possible, to harmonize our own federal common law rules with those of other federal courts of appeals." *Matinchek*, 93 F.3d at 101 (internal citations omitted).

Ninth Circuit's decision *In re Lowenschuss*, 171 F.3d 673, 680 (9th Cir.1999), *cert denied*, 528 U.S. 877, 120 S.Ct. 185, 145 L.Ed.2d 156 (1999), wherein the court had determined that the "status of the pension plan is determined as of the date of the bankruptcy filing," to find that the plan was no longer ERISA qualified. *In re Stern*, 345 F.3d at 1041. On appeal, the plaintiff argued that under the Ninth Circuit's precedent in *Peterson*, 48 F.3d at 407-08, the plan, which was ERISA qualified at its inception, should maintain its ERISA qualification, even though the plan currently covered only the plaintiff and his spouse. *In re Stern*, 345 F.3d at 1040-41. In *Peterson*, the Ninth Circuit had held that a plan remains ERISA qualified if it covers an employee other than the owner at the time the plan was established. *In re Stern*, 345 F.3d at 1041 (discussing *Peterson*, 48 F.3d at 407-08). Thus, the Ninth Circuit was tasked with reconciling its decision in *In re Lowenschuss* with its decision in *Peterson*.

The court ultimately determined that "the fact that *Peterson* concerned an employee welfare benefit plan and *In re Lowenschuss* addressed a pension plan is outcome determinative," as the definition of an employee welfare benefit plan focused on the past, whereas the definition of a pension plan focused on the present. *In re Stern*, 345 F.3d at 1041. The Ninth Circuit focused on the language of the two provisions:

> 29 U.S.C. § 1002(1) defines an ERISA-qualified welfare benefit plan as one "established or maintained . . . for the purpose

> of providing [benefits] for its participants or their beneficiaries[.]" 29 U.S.C. § 1002(1) (West 1999). In contrast, a pension plan is ERISA-qualified only "to the extent that by its express terms or as a result of surrounding circumstances [the pension plan] provides retirement income to employees . . ." 29 U.S.C. § 1002(2)(A)(i) (West 1999).

In re Stern, 345 F.3d at 1041 (alternations in original); *see also Peterson*, 48 F.3d at 408 ("Moreover, the ... policy originally covered a non-partner employee in addition to Peterson and his partner. A policy is governed by ERISA if it is '*established* or maintained by an employer . . . for the purpose of providing [medical insurance] for its participants or their beneficiaries.' " (emphasis in original) (citing 29 U.S.C. § 1002(1))). Thus, *In re Stern* makes clear that the ERISA status of an employee welfare benefit plan is determined at the time the plan is established, regardless of whether the plan participants change.

Because the Ninth Circuit is the only court of appeals that has examined this issue in depth, I will follow the reasoning of its decisions in *In re Stern* and *Peterson* and find that because the Leonards' insurance policy was covered by ERISA at its inception—i.e., at the time it was established—it continues to be covered by ERISA. Moreover, several district courts have adhered to this view as well. *E.g., Harman v. United Healthcare of Fla., Inc.*, 207 F.Supp.2d 1355, 1357 (M.D.Fla.2002) (finding that the insurance policy issued

met the statutory criteria for an employee welfare benefit plan and thus "ERISA continued to govern the plan after September, 2001, though [the insured] became the sole plan participant"); *Nix v. United Health Care of Ala., Inc.*, 179 F.Supp.2d 1363, 1369-1370 (M.D.Ala.2001) ("Applying the plain meaning of the statute, the court finds that the phrase 'established or maintained' by an employer covers the situation where, as here, an employer sets up an insurance plan for both owners and employees, but later all employees cease to work for the employer, leaving only the owners covered under the plan."); *Miller v. Provident Life & Accident Ins. Co.*, 2000 U.S. Dist. LEXIS 14694, at *12 (C.D.Cal. Sept. 5, 2000) ("The statutory definition's use of the word 'or' supports the Court's interpretation that an insurance policy that was part of an established ERISA plan is governed by ERISA even if the plan is no longer maintained as an ERISA plan by the employer."); *Jaffe v. Provident Life & Accident Ins. Co.*, 2000 U.S. Dist. LEXIS 4417, 3-4 (S.D.Fla. Apr. 4, 2000) (rejecting plaintiff's contention that because at the time of plaintiff's disability the welfare benefit plan did not cover a non-owner employee the plan was not governed by ERISA).[12]

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12. I note that one case from this district was presented with the question of whether employee attrition alters the ERISA status of an employee welfare benefit plan and came to the opposite result. In reaching its conclusion, the court in *Glickman v. United States Healthcare Systems of Pennsylvania., Inc.*, 268 F.Supp.2d 443 (E.D.Pa.2003), relied on *In re Lowenschuss*, 171 F.3d 673, and *Henglein v. Informal Plan for Plant Shutdown*

(Cont'd)

Appendix B

I also note that language from the Supreme Court's decision in *Yates* can be read to suggest that a plan should not lose ERISA status once it has been deemed an ERISA plan. The Supreme Court repeatedly noted that it would be anomalous to have disparate legal regimes apply to employees based on whether the employee was a working owner:

> Recognizing the working owner as an ERISA-sheltered plan participant also avoids the anomaly that the same plan will be controlled

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(Cont'd)

Benefits for Salaried Employees, 974 F.2d 391, 398 (3d Cir.1992). As described above, *Lowenschuss* is not persuasive as the Ninth Circuit has foreclosed its reach to ERISA welfare benefits plans as opposed to pension plans. In *Henglein*, the Third Circuit was tasked with determining whether the plaintiff-employees could prove the existence of an employee benefit plan under the test articulated in *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir.1982). *Henglein*, 974 F.2d at 398-99. The Third Circuit determined that the employees' claim that there was an informal employee benefit plan "must be resolved not under state law, but under ERISA, which refers to the surrounding circumstances to determine if a plan existed *at the time benefits were denied.*" *Id.* (emphasis added) (citing *Donovan*, 688 F.2d 1367). The district court in *Glickman*, as well as the parties in that case, took the phrase "at the time benefits were denied" to require the determination of the existence of an ERISA welfare benefit plan not at the plan's inception, but on the date the court determined that benefits were denied. *Glickman*, 268 F.Supp.2d at 446. Among several other reasons that the phrase from *Henglein* is not applicable here, in *Leckey*, the Third Circuit stated in no uncertain terms that it had not reached the issue of "when a plan's ERISA status ought to be determined," thus it was inappropriate to apply that phrase to this issue.

> by discrete regimes: federal-law governance for the nonowner employees; state-law governance for the working owner. ERISA's goal, this Court has emphasized, is uniform national treatment of pension benefits. Excepting working owners from the federal Act's coverage would generate administrative difficulties and is hardly consistent with a national uniformity goal.

Yates, U.S. at 16-17 (internal quotations and citations omitted). Later in the opinion, the Court summed up its holding and relied parenthetically on a case from the Fourth Circuit:

> Plans covering working owners and their nonowner employees, on the other hand, fall entirely within ERISA's compass. . . . [*Madonia v. Blue Cross & Blue Shield*, 11 F.3d 444, 449-50 (4th Cir.1993)] ("[T]he regulation does not govern the issue of whether someone is a 'participant' in an ERISA plan, once the existence of that plan has been established. This makes perfect sense: once a plan has been established, it would be anomalous to have those persons benefitting from it governed by two disparate sets of legal obligations.").

Id. at 21-22. Given the Supreme Court's stated concern that "the same plan will be controlled by discrete regimes," *id.* at 17, it would seem equally problematic for a plan to be deemed an ERISA plan at its inception—thus having federal law apply to both working owners

and other employees—only to have it subsequently lose its status and be governed by state law.[13] The Third Circuit has similarly acknowledged that it would be questionable to have different law apply to the same plan, stating that "creat[ing] the anomaly of requiring some insureds to pursue benefit claims under state law while requiring others covered by the identical policy to proceed under ERISA . . . would frustrate Congress's intent of achieving uniformity in the law governing employment benefits." *Wolk v. UNUM Life Ins. of Am.*, 186 F.3d 352, 357 (3d Cir.1999) (citing *Peterson*, 48 F.3d at 409) (internal quotations omitted). Moreover, recognizing that the protections of ERISA apply to the plan at issue also comports with "the intent of Congress 'that coverage under ERISA be construed liberally to provide the maximum degree of protection to working men and women covered by private retirement programs.' " *Deibler v. United Food & Commercial Workers' Local Union* 23, 973 F.2d 206, 209 n. 5 (3d Cir.1992) (citing S.Rep. No. 93-127 (1973), *reprinted in* 1974 U.S.Code Cong. & Admin. News 4639, 4854).[14]

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13. I note, however, that this concern is heightened in the circumstance described in *Yates* where a working owner may not be a plan participant with his or her employees because the federal and state regimes would operate contemporaneously with respect to the same plan.

14. Congress also stated the following with respect to the enactment of ERISA:

> It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of

(Cont'd)

Accordingly, I conclude that the plan at issue is governed by ERISA and this court has federal question subject matter jurisdiction. I will thus proceed to determine whether Educators is entitled to summary judgment on plaintiff's claim for benefits.

III. Summary Judgment Standard

A court may only grant a motion for summary judgement, "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. Pro. 56(c). "Facts that could alter the outcome are 'material,' and disputes are 'genuine' if evidence exists from which a rational person could conclude that the position of the person with the burden of proof on the disputed issue is correct." *Ideal Dairy Farms v. John Labatt, Ltd.*, 90 F.3d 737, 743 (3d Cir.1996) (citation omitted).

(Cont'd)

> participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

29 U.S.C. § 1001.

When a court evaluates a motion for summary judgment, "[t]he evidence of the non-movant is to be believed." *Anderson*, 477 U.S. at 255. In addition, "[a]ll justifiable inferences are to be drawn in [the non-movant's] favor." *Id.* "Summary judgment may not be granted . . . if there is a disagreement over what inferences can be reasonably drawn from the facts even if the facts are undisputed." *Ideal Dairy*, 90 F.3d at 744 (citation omitted). However, "an inference based upon a speculation or conjecture does not create a material factual dispute sufficient to defeat entry of summary judgment." *Robertson v. Allied Signal, Inc.*, 914 F.2d 360, 382 n. 12 (3d Cir.1990) (citation omitted). The non-movant must show more than "[t]he mere existence of a scintilla of evidence" for elements on which he bears the burden of production. *Anderson*, 477 U.S. at 252. Thus, "[w]here the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no 'genuine issue for trial.' " *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986) (citations omitted).

III. ERISA Standard of Review to be Applied to Educators's Decision to Deny Benefits

A. *Pinto*'s Heightened Arbitrary and Capricious Standard

The Supreme Court has explained that a decision to deny benefits "is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary authority to determine eligibility for

benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). When the administrator is given such discretion, the court generally should apply the "arbitrary and capricious" standard. In the Third Circuit, this means that a court should overturn the decision of a plan administrator "only if it is 'without reason, unsupported by substantial evidence or erroneous as a matter of law.' " *Abnathya v. Hoffman-La Roche, Inc.*, 2 F.3d 40, 45 (3d Cir.1993) (citations omitted).

Here, the parties dispute whether the benefit plan at issue grants Educators discretionary authority to determine eligibility for benefits and construe the terms of the Educators Policy. (Pl.'s Summ. J. Mem. 6; Def.'s Resp. 9.) The discretion required to trigger the arbitrary and capricious standard of review need not be expressly stated in the plan, but may be inferred from its terms. *Luby v. Teamsters Health, Welfare & Pension Trust Funds,* 944 F.2d 1176, 1180 (3d Cir.1991) (stating that no "magic words," such as "discretion is granted . . . ," need be expressly stated in order for the plan to grant the administrator discretion to interpret plan terms and to hear and decide disputes between alleged beneficiaries, so long as the plan on its face clearly grants such discretion (quoting *De Nobel v. Vitro Corp.*, 885 F.2d 1180, 1187 (4th Cir.1989))). With respect to the Clinic's plan, in a section entitled "Claims Provisions," under a subsection entitled "Loss," the plan stated:

> **You** must send **us** proof of loss within 90 days after the date the qualifying expenses are

> **incurred.** We will not decline or reduce a claim if: (a) it is not reasonably possible to give proof in that time; and (b) the proof is submitted within one year from the date of incurral. This one year period will not apply when **you** are not legally capable of submitted proof. All proofs of loss must be satisfactory to **us.**

(Pl.Ex. 13 at 26; Def. Ex. 2 at 26 (emphasis in original).) The requirement that the proof of loss "must be satisfactory to *us*" is sufficient implied reservation of discretion for the plan administrator to determine eligibility for benefits; thus, the arbitrary and capricious standard of review applies. *See Russell v. Paul Revere Life Ins. Co.*, 148 F.Supp.2d 392, 400 (D.Del.2001) ("Language requiring 'satisfactory proof' often implies an inference of discretion on the part of the plan administrator. In fact, several other circuit and district courts have found similar language to be discretionary in nature."), *aff'd*, 288 F.3d 78, 82 (3d Cir.2002); *Dorsey v. Provident Life & Accident Ins. Co.*, 167 F.Supp.2d 846, 853 (E.D.Pa.2001) (finding sufficient reservation of discretion where insurer's "policy states that benefits will only be awarded if there is 'proof of loss,' which is defined as written evidence satisfactory to [the insurer] that a claimant is disabled").

Plaintiff argues alternatively for *de novo* review because even if the plan "gave Educators discretion, it never effectively exercised it because Dr. Leonard was not informed of the result of its analysis until after this litigation began." (Pl. Mem. Opp'n Summ. J.) Plaintiff

cites *Gritzer v. CBS, Inc.*, 275 F.3d 291 (3d Cir.2002), where the Third Circuit held that even if the plan at issue grants discretion, where a trustee fails to act or exercise his or her discretion, *de novo* review is appropriate. *Id.* at 296. In *Grizter*, after the appellants made several unsuccessful inquires to the plan administrator, they filed a claim letter. *Id.* at 294. The plan administrator failed to respond within 90 days and thus, the appellants' claim was "deemed 'denied.' " *Id.* The appellants then filed suit in the district court and, nearly five months later, the plan administrator finally responded to their claim on the merits, denying them for the essentially the same reasons it invoked in the district court. *Id.* The Third Circuit held that the district court should have exercised *de novo* review because the plan administrator "apparently never made any effort to analyze appellants' claim much less to advise them of what that analysis disclosed until after this litigation was filed." *Id.* at 295. The court also addressed the plan administrator's contention that it "did eventually provide a written response, albeit after this litigation was commenced," concluding that "post-commencement-of-litigation determinations under the aegis of attorneys are not benefit eligibility analyses by a plan administrator to which a court must defer." *Id.* at 295 n. 4.

The factual situation in the case at bar is distinguishable. First, Educators did not fail to respond but provided plaintiff with its initial analysis of the Leonards' eligibility for coverage and was engaged in an attempt to analyze their claims, but needed addition

information, which it requested from them. (*See* Ex. A. of Def. Reply.) Thus, the Leonards were on notice of the potential issues regarding their claim and that Educators was endeavoring to make a final determination, but they failed to provide the additional information needed. Second, although Educators engaged in an administrative determination post commencement of litigation, this was by agreement of the parties specifically so the court could engage in an analysis pursuant to *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 378 (3d Cir.2000), of that administrative determination. (Hr'g, Jan 9, 2006 25:25-27:23.) While this was somewhat of a procedural irregularity, which will be taken into account in applying the *Pinto* factors, it does not mandate *de novo* review. Such a result would make the entire administrative review—to which the parties agreed—superfluous.

While I will not apply a *de novo* standard of review, the Supreme Court has made clear that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.' " *Bruch,* 489 U.S. at 115 (citation omitted). The Third Circuit has held that "when an insurance company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review." *Pinto,* 214 F.3d at 378.

In the present case, Educators both funds and administers benefits under the policy. Accordingly, the

"heightened form" of the arbitrary and capricious standard of review, as described in *Pinto*, applies to this case. This "heightened form" requires courts "to consider the nature and degree of apparent conflicts with a view to shaping their arbitrary and capricious review of the benefits determinations of discretionary decisionmakers." *Pinto*, 214 F.3d at 393. More specifically, the court in *Pinto* established "a sliding scale method, intensifying the degree of scrutiny to match the degree of the conflict," so that the arbitrary and capricious standard is "more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is." *Id.* at 379, 392-93 (citations omitted).

Pinto offered a nonexclusive list of factors for courts to consider in assessing the nature and degree of the structural conflict of interest. *Id.* at 392. These factors include: (1) the sophistication of the parties; (2) the information accessible to the parties; (3) the exact financial arrangement between the insurer and the company; and (4) the status of the administrator, since the company's financial or structural deterioration might negatively impact the presumed desire to maintain employee satisfaction. *Pinto*, 214 F.3d at 392.

In addition to the four factors discussed above, the *Pinto* court stated that courts should "look not only at the result—whether it is supported by reason—but at the process by which the result was achieved." *Id.* at 393; *see also Kosiba v. Merck & Co.*, 384 F.3d 58, 66 (3d Cir.2004) ("Our precedents establish at least one more cause for heightened review: demonstrated procedural

irregularity, bias, or unfairness in the review of the claimant's application for benefits."). The "procedural anomalies" in *Pinto* were: "(1) the insurer's reversal of its original determination without the examination of additional evidence; (2) a self-serving selectivity in the use of evidence; and (3) a bias in decision-making to the benefit of the insurer." *Russell,* 148 F.Supp.2d at 406 (D.Del.2001) (interpreting and citing *Pinto*). The burden of proof is on the claimant to show a heightened standard of review is warranted in a particular case. *See Kotrosits v. GATX Corp. Non-Contributory Pension Plan for Salaried Employees,* 970 F.2d 1165, 1173 (3d Cir.1992). Plaintiff asserts that the procedural anomalies coupled with the *Pinto* factors require that Educators's determination be reviewed under a heightened arbitrary and capricious review that essentially equals *de novo* review.

B. Factors Demonstrating a Structural Conflict of Interest

To reiterate, *Pinto* found that in determining the severity of a structural conflict of interest, courts should consider "the sophistication of the parties, the information accessible to the parties, . . . the exact financial arrangement between the insurer and the company . . . [and] the current status of the fiduciary." *Pinto,* 214 F.3d at 392. These factors will be discussed in turn.

With reference to the issue of the sophistication of the parties, plaintiff argues that this factor weighs in

favor of heightening the scrutiny because that plaintiff was not sophisticated in terms of ERISA, never saw the Group Administration Manual, and did not discuss the employee eligibility requirements with his insurance agent or anyone at Educators. (Pl. Mem. Opp'n Summ. J. 8 (citing Leonard Dep. 85, 89, 114).) Educators argues that its eligibility determination did not require a sophisticated knowledge of eligibility requirements but merely whether the Leonards were full-time employees, which Dr. Leonard misrepresented. (Def.Mem.Supp. Summ. J.) I find there was a sophistication imbalance between the parties as Dr. Leonard would not have had ERISA or claims experience, whereas Educators has reviewed numerous such claims. *See Stratton v. E.I. DuPont de Nemours & Co.*, 363 F.3d 250, 254 (3d Cir.2004). However, Dr. Leonard was represented by counsel during the administrative process. Accordingly, this factor warrants some heightening of the standard of review. *See Post v. Hartford Ins. Co.*, 2005 U.S. Dist. LEXIS 22511, **30-31 (E.D.Pa. Oct. 5, 2005).

The information accessible to the parties does not weigh in favor of heightening the standard of review. By the time the Educators made its final administrative determination, discovery in preparation for trial had been accomplished; both parties had made disclosures to each other and submitted to the court proposed findings of fact. Moreover, even before Educators brought suit in the Court of Common Pleas, it had provided the Leonards with the reasons it had suspended claims processing.

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The financial arrangement between the insurer and the company merits substantial heightening of the standard of review. There is no longer any relationship between the Clinic and Educators, thus there is nothing to mitigate Educators's incentive to deny individual requests. *See Pinto*, 214 F.3d at 392 (stating with respect to this factor that "a court can consider whether the insurance contract is fixed for a term of years or changes annually, and whether the fee paid by the company is modified if there are especially large outlays of capital").

The fourth factor—the current status of the fiduciary—also warrants substantial heightening of the standard of review as Educators is no longer in the health insurance market. In *Pinto*, the Third Circuit pointed out that previous cases "generally assume that the company is stable and will act as a repeat player." 214 F.3d at 392. However, "[w]hen companies are breaking up, or laying off a significant percentage of their employees, or moving all their operations, [the incentive to maintain employee satisfaction is] diminish[ed] significantly." *Id.* Although Educators remains in the market for life, dental and short- and long-term disability insurance, (*see* Rankin Dep. 7-8), and thus has some general reputational interest, its incentive to maintain employee satisfaction is greatly diminished. Thus, both the third and fourth factors weigh strongly in favor of substantially heightening the standard of review.

C. Procedural Anomalies

Plaintiff argues that procedural irregularities also dictate an elevated standard of review. Plaintiff asserts that Educators's first concerns about Dr. Leonard's coverage are remarkably coincidental with the date of his first submission of extensive bills for heart bypass surgery. (Pl. Mem. Opp'n Summ. J. 10.) Plaintiff points to an internal email from Educators's claims staff, sent within ten days of Dr. Leonard's bypass surgery, which states: "I need to stop all claim payments for Harold Leonard . . . and his wife, Diane." (*Id.* (citing Pl.Ex. 27).) Taking this evidence in the light most favorable to plaintiff, it appears procedurally irregular that Educators would begin to question the Leonards' eligibility for claims at a time so contemporaneous with Dr. Leonard's surgery.

Plaintiff also takes issue with the length of time it took Educators to make determinations. (Pl. Mem. Opp'n Summ. J. 10.) Plaintiff explains that under the applicable regulations, an ERISA fiduciary has forty-five days from the date of receipt of the benefits claim to make an initial decision, with a permissible extension of fifteen days, 29 C.F.R. § 2560.503-1(f)(2)(iii)(B), but no EOBs were ever issued. This is also procedurally irregular as it appears from the record that the first written notice plaintiff received concerning the status of these claims was the letter from counsel dated September 15, 2003. Plaintiff also contends that the fact that Educators did not make a final administrative determination until after it filed the declaratory

judgment suit in the Court of Common Pleas, where its position regarding coverage was made clear in a verified complaint, weighs in favor of heightening the standard of review. This is also irregular; however, as stated above, the parties agreed to placing the case in civil suspense pending the administrative review and Educators appeared poised to make an administrative determination pre-litigation, but had not received necessary documentation from the Leonards, which plaintiff does not contest.

Taking all the factors that weigh in favor of heightening scrutiny together—most significantly the financial arrangement between the parties, the current status of the fiduciary and the timing of the initial concerns regarding the Leonards' insurance—I will apply a standard of review "on the far end of the arbitrary and capricious 'range.' " *Pinto*, 214 F.3d at 394. Thus, while "a court may not substitute its own judgment for that of plan administrators under either the deferential or heightened arbitrary and capricious standard," *Stratton*, 363 F.3d at 256 (quoting *Smathers v. Multi-Tool, Inc./Multi-Plastics, Inc.*, 298 F.3d 191, 199 (3d Cir.2002)), I will "examine the facts before the administrator with a high degree of skepticism," *Pinto*, 214 F.3d at 394.

IV. Discussion

The issue before the court is whether Educators acted arbitrarily and capriciously under the heightened standard in determining that the Leonards were not

eligible for benefits within the meaning of the Educators Policy. In this analysis, the court may review only the evidence that was before Educators at the time the determination was made. *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 440 (3d Cir.1997).

Educators ultimately concluded that the Leonards were ineligible for coverage since at least 1997 because (1) the Clinic was no longer in operation; (2) there were not at least two employees as required by a group policy; (3) neither Dr. nor Diane Leonard was working at least thirty hours per week in the operation of the Clinic's business receiving full compensation for their services, and (4) Dr. Leonard consistently misrepresented material facts. (Def.Ex. 25.) Educators also concluded that Dr. Leonard was motivated to make misrepresentations because he was required in his divorce to purchase individual coverage for Diane Leonard, which would have been substantially more expensive than the Educators group policy. Plaintiff appears to combine his objections to Educators's administrative determination with his assertion that there was no fraud in the application for insurance. These are two separate bases for denying benefits. However, I will attempt to address all of plaintiff's contentions that apply to whether the decision of Educators was not supported by the record.

It cannot be said that the decision to deny benefits based on the Leonards' ineligibility under the policy was "without reason, unsupported by substantial evidence or erroneous as a matter of law," even when viewing the

facts before Educators "with a high degree of skepticism." The terms of the Educators plan are unambiguous. *See Bill Gray Enters. v. Gourley*, 248 F.3d 206, 218 (3d Cir.2001) ("Whether terms in an ERISA Plan document are ambiguous is a question of law. A term is ambiguous if it is subject to reasonable alternative interpretations." (quotation omitted)).

The policy in question is a group PPO policy to Dr. Leonard and the Clinic providing group medical insurance benefits. Educators did not issue individual policies. The employer was the Leonard Clinic of Chiropractic. It is undisputed that Dr. Leonard sold the Clinic in 1993. Thereafter there was a period of time when he returned to school and later his chiropractic license was declared inactive. He did open a business in Maryland but it is undisputed that this business closed in September of 1999. The medical expenses which are the subject of the current claims began accruing in June of 2003. Nowhere does plaintiff allege that there was a clinic operating at that time owned by him.

The policy provides that employees must perform "all of the duties of your job with a covered employer on a full-time basis." In order to be full-time the employee must "regularly work for the covered employer at least thirty hours per week; and be on the regular payroll of the covered employer for that work." As of the time of the application for the policy in December of 1997 and as of the time of the accrual of the claim for the benefits at issue, it is undisputed that Diane Leonard was neither working for a covered employer at least thirty

hours per week nor that she was on the regular payroll of the covered employer for that work. The parties agree that Dr. Leonard and Diane Leonard separated in June of 1997 and that thereafter she neither worked on a full-time basis for the Clinic (defined as at least thirty hours per week) nor was on a regular payroll of the Clinic. Thus, by at least June of 1997 there were never two employees by any stretch of the evidence and indisputably Diane Leonard was not an employee.

Likewise, it is undisputed that Dr. Leonard sold the Leonard Clinic of Chiropractic in 1993, returned to school from February of 1994 through some time in 1995 and allowed his chiropractic license in Pennsylvania to become inactive on June 1, 1995. He performed chiropractic services in Maryland for a period of time but that terminated in September of 1999. While he may have performed some consulting services thereafter, there is no evidence that he worked for the covered employer (the Clinic) that he worked at least thirty hours per week as required by the policy or that he was on the regular payroll of the Clinic for that work. Thus, he too was indisputably not an employee at the time the claims accrued.

The policy provides that the medical coverage terminates on the date the employer ceases to be a covered employer or the date the employee was no longer an active employee. Dr. Leonard provides no evidence that either he or Diane Leonard was an active employee at the relevant time.

Thus, these two bases supporting Educators's denial of benefits for the Leonards are reasonable and cannot be said to be arbitrary and capricious, even under a significantly heightened standard of review.[15, 16]

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15. Educators determination that "as of December 1, 1997, the Clinic, in terms of a Lancaster-based business was no longer in operation," is a somewhat ambiguous conclusion and not entirely supported by record evidence. It is not clear when Dr. Czop ceased operating in that space or when the name was officially changed. In fact, plaintiff avers that he continued to do consultations with Dr. Czop and various insurance companies at the Manheim Pike office until it closed in 2000. What is clear is that it was no longer Dr. Leonard's primary place of employment, although he continued to maintain a mailbox there and was forwarded mail. However, this fact is not material because ample evidence supports Educators's determination that Dr. Leonard and Diane Leonard were not eligible under the policy.

Educators's conclusion that Dr. Leonard was motivated to make misrepresentations on the application for insurance because of the court order in his divorce proceedings that he provide insurance coverage for Diane Leonard is also not supported by record evidence. The only supporting evidence in the administrative record is the order of the court requiring Dr. Leonard to provide coverage (Def.Ex. 17) and a letter apparently from Dr. Leonard's divorce attorney to Diane Leonard's attorney opining about the cost of insurance coverage (Def.Ex. 22). It is not reasonable to make such an inferential leap. Moreover, Dr. Leonard has specifically averred to the contrary that the Educators policy was actually more expensive than an individual policy, which I must treat as true for purposes of this motion. In any event, because I have determined that Educators's decision was reasonable for other reasons, this is not an issue of material fact.

16. I would reach the same result even if I were to apply a de novo standard of review.

See Clark v. Hartford Life & Accident Ins. Co., 2006 U.S. Dist. LEXIS 84122, at *16 (E.D.Pa. Nov. 16, 2006) (granting summary judgment in favor of insurer where the "denial of benefits was not arbitrary or capricious because [the insurer] applied the uncontroverted facts to the unambiguous language of the policy and made the right determination"). Accordingly, I will grant summary judgment in favor of Educators on plaintiff's remaining claim in his complaint.[17] An appropriate order follows.

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17. In its memorandum of law in support of summary judgment, Educators also raised the issue of whether the policy was void as a result of misrepresentations on the application. I will not reach this issue. First, to the extent that Educators posits misrepresentations made by plaintiff as an alternative basis for denying coverage, I need not reach that issue because I have already determined that Educators's determination that Dr. and Diane Leonard were not eligible employees was reasonable. Second, to the extent that Educators raises the issue of misrepresentation because it seeks summary judgment in its favor on its counterclaim, Educators's motion only requested the court grant summary judgment in its favor on *plaintiff's* claims. Finally, despite the fact that all parties have proceeded under the assumption that ERISA governs the policy in this case, they have addressed the issue of misrepresentation under Pennsylvania law. However, ERISA preempts such a claim. Section 1144(a) of ERISA provides that ERISA's provisions supersede "any and all state laws insofar as they may or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This preemption is "deliberately expansive." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). According to the Third Circuit, a state law claim relates to an ERISA employee benefit plan if: (1) the existence

(Cont'd)

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of an ERISA plan is critical to establishing liability and (2) the court's inquiry would be directed to the plan. *See 1975 Salaried Retirement Plan v. Nobers*, 968 F.2d 401, 406 (3d Cir.1992). As a consequence, federal common law governs an insurer's decision to rescind coverage based on a insured's material misrepresentation. *See McBride v. Hartford Life & Accident Ins. Co.*, 2007 U.S. Dist. LEXIS 16917, *63 (E.D.Pa. Jan. 29, 2007) ("Federal common law permits rescission of ERISA policies for material misrepresentations or omissions if they are: (1) false, (2) made with knowledge of their falsity, (3) material, and (4) relied upon by the insurer.") (citing *Shipley v. Ark. Blue Cross & Blue Shield*, 333 F.3d 898, 904-06 (8th Cir.2003)).

Appendix B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 04-5310

HAROLD L. LEONARD,
d/b/a The Leonard Clinic of Chiropractic,

Plaintiff,

v.

EDUCATORS MUTUAL LIFE INSURANCE CO.,

Defendant.

ORDER

AND NOW, this _____ day of October, 2007, upon consideration of defendant Educators Mutual Life Insurance Company's motion for summary judgment (Docket No. 28), plaintiff's response, and defendant's reply, as well as the parties' supplemental briefing on the issue of this court's subject matter jurisdiction, it is hereby ORDERED that defendant's motion for summary judgment is GRANTED and judgment is ENTERED in favor of defendant Educators Mutual Life Insurance Company and against plaintiff Dr. Harold Leonard d/b/a The Leonard Clinic of Chiropractic on plaintiff's complaint.

APPENDIX C — MEMORANDUM AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA FILED DECIDED MAY 5, 2005

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 04-5310

HAROLD L. LEONARD and THE LEONARD CLINIC OF CHIROPRACTIC,

Plaintiffs,

v.

EDUCATORS MUTUAL LIFE INSURANCE COMPANY,

Defendant.

MEMORANDUM AND ORDER

YOHN, J.

This case arises out of an insurance dispute over unpaid medical benefits. Initially, the defendant in this case, Educators Mutual Life Insurance ("Educators"), brought suit in Pennsylvania state court seeking a declaratory judgment that its group insurance policy with plaintiffs Harold Leonard and The Leonard Clinic

of Chiropractic ("the Clinic") was null and void.[1] Next, plaintiffs filed a counterclaim in state court under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA") to recover unpaid medical benefit owed under the policy.[2] While the suit in state court was pending, plaintiffs filed suit in this court seeking similar relief under ERISA. Presently before the court is Educators' motion to dismiss the federal complaint pursuant to Federal Rule of Civil Procedure 12(b)(6). It requests that the court decline to exercise jurisdiction over the case, and instead defer to the parallel state court proceedings pursuant to the *Colorado River* abstention doctrine. *See Colo. River Water Conservation Dist. v. United States*, 424 U.S. 800, 96 S.Ct. 1236, 47 L.Ed.2d 483 (1976). For the reasons set forth below, I will deny the motion.

I. BACKGROUND[3]

Plaintiff Harold Leonard operates the Clinic as a sole proprietor. In 1990, Leonard purchased group medical and life insurance coverage for the Clinic's

1. Educators named Harold Leonard, his wife, Diane Leonard, and the Clinic in its original state court complaint. The complaint also alleged one count for common law fraud.

2. The counterclaim also brought one count for breach of contract and one count under Pennsylvania's Unfair Insurance Practices Act, 40 Pa. Cons.Stat. § 1171.1 *et seq.*

3. I have assembled the following facts from the allegations in the state and federal court complaints and plaintiffs' state court counterclaim.

employees from Educators. The policy covers active employees of the Clinic and their dependants. To remain eligible under the policy, the Clinic must remain "an active and ongoing business operation." Through 1998,[4] Leonard and his wife Diane both received coverage through the Clinic's policy with Educators. However, at some point after January 1, 1998, Educators began refusing to pay medical bills submitted by the Leonards.[5] Educators contends that its policy with the Clinic became null and void as of December 1, 1997 because the Clinic made misrepresentations in its October 30, 1997 application to renew coverage. Educators alleges that the Clinic ceased business operations prior to October 30, 1997, but in its subsequent renewal application, the Clinic represented that it was "an active and ongoing business operation."

On April 7, 2004, Educators filed suit in the Court of Common Pleas of Lancaster County, Pennsylvania against Harold Leonard, Diane Leonard, and the Clinic. The complaint seeks a declaratory judgment that Educators' policy with the Clinic is null and void, and consequently, that it is not responsible for the Leonards' outstanding medical bills. On June 30, 2004, plaintiffs filed a counterclaim against Educators, alleging breach of

4. Neither party indicates when the Leonards stopped paying for coverage with Educators.

5. According to the state court complaint, since January 1, 1998, Educators has refused to pay $201,851.05 in medical bills that have been submitted by Harold Leonard and $23,543.00 in medical bills that have been submitted by Diane Leonard. Educators claims that it has paid $8,165.31 of Harold Leonard's medical bills and $135,573.88 of Diane Leonard's medical bills.

contract and violations of ERISA and Pennsylvania's Unfair Insurance Practices Act, 40 Pa. Cons.Stat. § 1171.1 *et seq.* In their ERISA claim, plaintiffs sought to recover unpaid medical benefits and attorneys' fees pursuant to 29 U.S.C. § 1132(a)(1)(B)[6] and § 1132(g)(1).[7, 8] Six months later, on December 10, 2004, plaintiffs filed the instant suit in this court. The complaint brings two causes of action under ERISA. Plaintiffs first claim is identical to their ERISA claim in state court. Plaintiffs second claim alleges breach of fiduciary duty pursuant to 29 U.S.C. § 1109 and § 1132(a)(2).[9, 10]

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6. This section provides that "a participant or beneficiary" of a "employee benefit plan" may bring a civil action "to recover benefits due to him under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

7. This provision states that in any action arising under ERISA, "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." 29 U.S.C. § 1132(g)(1).

8. ERISA provides that state courts have concurrent jurisdiction with United States district courts over actions arising under § 1132(a)(1)(B). 29 U.S.C. § 1132(e)(1).

9. Section 1109 provides that "[a]ny person who is a fiduciary with respect to a plan who breaches any of the responsibilities . . . imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach. . . ." Section 1132(a)(2) authorizes "a participant or beneficiary or fiduciary" to sue for "appropriate relief under section 1109."

10. Unlike plaintiffs' § 1132(a)(1)(B) claim, federal courts have exclusive jurisdiction over plaintiffs' breach of fiduciary duty claim. 28 U.S.C. § 1132(e)(1).

On January 27, 2005, Educators filed the instant motion to dismiss. Five days later, in an effort to moot the motion, plaintiffs withdrew their ERISA claim in state court. Educators' preliminary objections to the remaining counts of plaintiffs' state court counterclaim are currently pending.

II. STANDARD OF REVIEW

In ruling on a motion to dismiss under Rule 12(b)(6), the court must accept as true all well-pled allegations of fact in the plaintiff's complaint, and any reasonable inferences that may be drawn therefrom, to determine whether "under any reasonable reading of the pleadings, the plaintiff may be entitled to relief." *Nami v. Fauver*, 82 F.3d 63, 65 (3d Cir.1996); *Colburn v. Upper Darby Township*, 838 F.2d 663, 665-66 (3d Cir.1988) (citations omitted). Although the court must construe the complaint in the light most favorable to the plaintiff, it need not accept as true legal conclusions or unwarranted factual inferences. *See Conley v. Gibson*, 355 U.S. 41, 45-46, 78 S.Ct. 99, 2 L.Ed.2d 80 (1957). Courts will grant a 12(b)(6) motion to dismiss "only if it is clear that no relief could be granted under any set of facts that could be proved consistent with the allegations." *Hishon v. King & Spalding*, 467 U.S. 69, 73, 104 S.Ct. 2229, 81 L.Ed.2d 59 (1984).

III. DISCUSSION

Federal courts have a "virtually unflagging obligation . . . to exercise the jurisdiction given them." *Colo. River*, 424 U.S. at 817 (citation omitted). Thus, generally, " 'the pendency of an action in . . . state court is no bar to proceedings concerning the same matter in the Federal court having jurisdiction. . . .' " *Id.* (citation omitted). Nonetheless, in *Colorado River*, the Supreme Court held that when there are concurrent state proceedings, in "exceptional" circumstances, a district court may stay or dismiss a case for reasons of "wise judicial administration." *Id.* at 817-18.[11]

A. Whether the state and a federal proceedings are parallel?

Before a district court may abstain on the basis of parallel state proceedings, the court must confirm that the proceedings are truly parallel. *See Trent v. Dial Med. of Fla., Inc.*, 33 F.3d 217, 223 (3d Cir.1994) ("Cases that are not truly duplicative do not invite *Colorado River* deference.") (overruled in part on other grounds in *Ryan v. Johnson*, 115 F.3d 193, 198-99 (3d Cir.1997)). Generally, cases are considered parallel when "they

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11. Unlike other so-called "abstention" doctrines, *Colorado River* abstention is "unrelated to considerations of proper constitutional adjudication and regard for federal-state relations." *Colo. River*, 424 U.S. at 817. For a review of the three constitutionally-based abstention doctrines *see id.* at 814-16. *See also Trent v. Dial Med. of Fla., Inc.*, 33 F.3d 217, 223 n. 5 (3d Cir.1994).

involve the same parties and claims." *Id.* However, "[t]o be parallel, the cases need not be identical in every respect." *Benninghoff v. Tolson*, No. 94-2903, 1994 U.S. Dist. LEXIS 13428, at *5 (E.D.Pa. Sept. 22, 1994) (citation omitted). Rather, "there must be a substantial likelihood that the state litigation will dispose of all the claims presented in the federal case." *CFI of Wis., Inc. v. Wilfran Agric. Indus., Inc.*, No. 99-1322, 1999 U.S. Dist. LEXIS 16896, at *5 (E.D.Pa. Nov. 1, 1999) (citation omitted). Courts have found that if a state court defendant brings a claim in federal court that could have been brought as a counterclaim in state court, "the cases are . . . not meaningfully different." *Allied Nut and Bolt, Inc. v. NSS Indus., Inc.*, 920 F.Supp. 626, 630 (E.D.Pa.1996); *see also CFI of Wis., Inc.* 1999 U.S. Dist. LEXIS 16896, at *5-*6 ("Courts have held that two actions are parallel even though a party must amend its pleadings in the state court to raise all claims.") (citations omitted).

Plaintiffs contend that the two cases are no longer parallel because it withdrew its ERISA claim in state court. Plaintiffs in federal court may moot *Colorado River* issues by withdrawing a parallel state court action. *See Cohen v. Township. of Cheltenham*, 174 F.Supp.2d 307, 319 (E.D.Pa.2001). In *Cohen*, the court concluded that *Colorado River* abstention was inappropriate after the plaintiffs withdrew their entire state court action because "there simply [were] no concurrent parallel proceedings." *Id.* Here, plaintiffs did not withdraw their entire counterclaim. Instead, they merely withdrew the one count that was facially identical to the federal

complaint. However, because cases need not be identical to be parallel, plaintiffs' cannot moot Educator's motion by withdrawing one claim if there remains "a substantial likelihood that the state litigation will dispose of all the claims presented in the federal case." *CFI of Wis.*, 1999 U.S. Dist. LEXIS 16896, at *5.

Here, even after plaintiffs' withdrew their ERISA counterclaim in state court, the two cases appear substantially similar. Both proceedings involve the same parties and arise out of the same insurance policy. Further, Educators' state declaratory judgment action, plaintiffs' state counterclaims, and plaintiffs' first ERISA claim will all turn on the validity of plaintiffs' insurance policy.

Nonetheless, despite the similarities between the two actions, the cases are not parallel because plaintiffs' federal suit includes a claim that falls within the exclusive jurisdiction of the federal courts. Plaintiffs second count alleges that Educators breached their fiduciary duties in violation of 29 U.S.C. § 1109 and § 1132(a)(2). Federal courts have exclusive jurisdiction over such claims. *See* 29 U.S.C. § 1132(e)(1) ("Except for actions under subsection (a)(1)(B) of this section the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter. . . ."). Three courts of appeals have concluded that courts may not abstain from exercising jurisdiction under *Colorado River* when one of the claims in the federal proceeding

falls within exclusive federal jurisdiction.[12] *See Medema v. Medema Builders, Inc.*, 854 F.2d 210, 215 (7th Cir.1988) ("In one class of cases, those where a plaintiff's nonfrivolous claim invokes the exclusive jurisdiction of federal courts, the *Colorado River* stay is not appropriate."); *Andrea Theatres, Inc. v. Theatre Confections, Inc.*, 787 F.2d 59, 62 (2d Cir.1986) ("[A]bstention is clearly improper when a federal suit alleges claims within the exclusive jurisdiction of the federal courts."); *Silberkleit v. Kantrowitz*, 713 F.2d 433, 436 (9th Cir.1983) ("The district court has no discretion to stay proceedings as to claims within exclusive federal jurisdiction under the wise judicial administration exception."). The Third Circuit has suggested, in dicta, that it would come to a similar conclusion. *See University of Md. v. Peat Marwick Main & Co.*, 923 F.2d 265, 276 n. 16 (3d Cir.1991) ("Although we have not resolved the question as to whether Commonwealth Court jurisdiction over the policyholders' claims exists, we observe that there can be no possible basis for abstaining if the state court to which the federal court defers lacks jurisdiction over the claim."); see *also Steiert v. Mata Servs.*, 111 F.Supp.2d 521, 528 (D.N.J.2000) ("[T]he exclusive federal nature of Plaintiffs' . . . claims lends strong force to the Court's conclusion that the proceedings are not truly parallel.")

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12. The Supreme Court raised this issue but failed to resolve it in *Will v. Calvert Ins. Co.*, 437 U.S. 655, 98 S.Ct. 2552, 57 L.Ed.2d 504 (1988). *See* Erwin Chemerinsky, Federal Jurisdiction, at 855 (4th ed.2003).

(citing *University of Md.*, 923 F.2d at 276 n. 16).[13] The *University of Maryland* court reasoned that "[i]f the [plaintiffs'] claims are not subject to review in a state forum, there can be no 'parallel' state court litigation on the basis of which a federal court could exercise *Colorado River* abstention." *Id.*

Courts and commentators have advanced an additional reason why federal courts should not abstain on *Colorado River* grounds when a claim falls within their exclusive jurisdiction. If federal courts defer to state courts in cases involving exclusively federal claims, the federal courts may eventually have to decide the exclusively federal claims because the state courts have no jurisdiction to hear them. Such a result surely does not advance *Colorado River*' s goal of "wise judicial administration."[14] *See Andrea Theatres*, 787 F.2d at 62 ("Absent broad state court jurisdiction that would enable the state court to dispose of the entire matter, including the issues before the federal court, abstention

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13. In cases applying other abstention doctrines, the Third Circuit has similarly concluded that "abstention is inappropriate in cases in which federal courts have exclusive jurisdiction over at least a portion of the claims presented." *Chiropractic Am. v. LaVecchia*, 180 F.3d 99, 108 (3d Cir.1999) (considering whether to abstain on the basis of *Burford* abstention); *see also Riley v. Simmons*, 45 F.3d 764, 773 (3d Cir.1995).

14. This rationale suggests that when a suit contains some exclusively federal claims, federal courts should not abstain from hearing any part of the suit even if state courts may adjudicate some of the claims.

could hardly be justified on grounds of 'wise judicial administration, giving regard to conservation of judicial resources and comprehensive disposition of litigation.' ") (quoting *Co. River*, 424 U.S. at 817); *Medema*, 854 F.2d at 215 ("[I]f preclusive effect is not given to state law determinations of exclusively federal claims . . . a stay does not advance *Colorado River*' s purpose of avoiding piecemeal litigation.") *see also* Erwin Chemerinsky, Federal Jurisdiction, at 856 (4th ed.2003).

Here, the state and federal proceedings are not truly parallel because the federal litigation may require the court to make determinations under exclusively federal law, which the state court may not decide. *See University of Md. v. Peat Marwick Main & Co.*, 923 F.2d at 276 n. 16. Further, even if I abstained from considering plaintiffs' first count, which may be decided in state court, ultimately, I may have to consider plaintiffs' breach of fiduciary duty claim because the state court may not. Under these circumstances, abstention would not further *Colorado River*' s goal of "wise judicial administration." Because the state and federal action are not truly parallel, the court may not abstain from considering plaintiffs' suit.

B. *Colorado River* factors

Even if the federal and state litigation were parallel, *Colorado River* abstention would be inappropriate. A federal court may only abstain under *Colorado River* in "exceptional" circumstances. *Colo. River*, 424 U.S. at 818. In *Moses H. Cone Memorial Hospital v. Mercury*

Construction Corp., 460 U.S. 1, 103 S.Ct. 927, 74 L.Ed.2d 765 (1983), the Supreme Court reexamined the *Colorado River* doctrine and articulated the following six factors to determine whether a district court should abstain for reasons of "wise judicial administration":

> (1) Which court first assumed jurisdiction over property involved, if any:
>
> (2) Whether the federal forum is inconvenient;
>
> (3) The desirability of avoiding piecemeal litigation;
>
> (4) The order in which the respective courts obtained jurisdiction;
>
> (5) Whether federal or state law applies; and
>
> (6) Whether the state court proceeding would adequately protect the federal plaintiff's rights.

Trent, at 33 F.3d at 2225 (citing *Moses H. Cone*, 460 U.S. at 15-16, 19-26). The *Moses H. Cone* Court further explained that "the decision whether to dismiss a federal action because of parallel state-court litigation does not rest on a mechanical checklist, but on a careful balancing of the important factors as they apply in a given case, with the balance heavily weighted in favor of the exercise of jurisdiction." 460 U.S. at 16.

Application of the factors suggests that abstention is inappropriate. The first factor is not relevant because there is no dispute over *in rem* jurisdiction or property rights. The second factor also carries little weight because Educators concedes that the federal courthouse in Philadelphia and the state courthouse in Lancaster[15] are equally convenient forums for the adjudication of this matter.

Educators primarily relies on the third factor, which considers the "desirability of avoiding piecemeal litigation." "*Colorado River* abstention must be grounded on more than just the interest in avoiding duplicative litigation." *Spring City Corp. v. Am. Bldgs. Co.*, 193 F.3d 165, 172 (3d Cir.1999). To justify abstention on the basis of concurrent litigation, there must be "a strongly articulated congressional policy against piecemeal litigation in the specific context of the case under review." *Ryan*, 115 F.3d at 198. Educators argues that ERISA reflects just such a policy because it provides state courts with concurrent jurisdiction over certain claims arising under the statute. *See* 29 U.S.C. § 1132(e)(1). In *Colorado River*, 424 U.S. at 819, the court found that the McCarran Amendment, 43 U.S.C. § 666, which provides that the United States may be joined as a party in water rights cases pending in state court, evidences a clear preference for state courts and a clear policy against piecemeal adjudication because it deprives the United States of its right to adjudication in a federal forum. *See also Moses H. Cone*, 460 U.S. at

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15. Lancaster County is located in this judicial district.

16 (summarizing the reasoning in *Colorado River*). Here, ERISA certainly does not express a strong congressional policy against piecemeal adjudication. Congress must have contemplated the possibility of parallel ERISA litigation in state and federal court because while it gives state courts concurrent jurisdiction over some ERISA claims, it vests federal courts with exclusive jurisdiction over other claims arising under the statute. *See* 29 U.S.C. § 1132(e)(1). Further, unlike the McCarran Amendment, ERISA reflects a congressional preference for federal courts because it grants them exclusive jurisdiction over some claims and its legislative history contemplates the development of "a body of Federal substantive law." 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits). Hence, the third *Colorado River* factor does not support abstention.

The fourth factor, which looks at "the order in which the respective courts obtained jurisdiction," arguably favors abstention. Under this factor, courts must consider "which complaint was filed first" and "how much progress has been made in the two actions." *Moses H. Cone*, 460 U.S. at 21. The state proceeding was filed eight months before the federal suit. Nonetheless, Educators has failed to come forward with any evidence about the progression of either case. As the moving party, Educators bears the burden of showing that abstention is warranted. *See Southeastern Pa. Transp. Auth. v. Am. Coastal Indus., Inc.*, 682 F.Supp. 285, 286 (E.D.Pa.1988) ("[The moving party] bears the burden of showing that 'there exist "exceptional"

circumstances, the "clearest of justifications," that can suffice . . . to justify the surrender of [federal] jurisdiction." ') (alteration in original) (quoting *Moses H. Cone*, 460 U.S. at 25-26). Hence, because Educators has failed to show that the state proceedings have progressed substantially further than the federal proceedings, the mere fact that the state case was filed first does not weigh heavily in favor of *Colorado River* abstention.

The final two factors weigh strongly against abstention. Although the presence of state-law issues may occasionally weigh in favor of abstention, the Supreme Court has emphasized that "the presence of federal-law issues must always be a major consideration weighing against [abstention]." *Moses H. Cone*, 460 U.S. at 26. Here, the federal suit arises solely under ERISA and thus raises exclusively federal issues. Further, because plaintiffs' federal complaint contains a claim that falls within the exclusive jurisdiction of the federal courts, the state court proceedings could not adequately protect plaintiffs' rights since the court cannot even hear one of plaintiffs' claims.[16] *See McConnell v. Costigan*,

16. Educators claims that the state proceedings can adequately protect plaintiffs' rights because plaintiffs voluntarily invoked the state court's concurrent jurisdiction by bringing an ERISA cause of action in their counterclaim. This argument wholly ignores the fact that plaintiffs' federal suit includes an exclusively federal claim that state courts may not adjudicate. Thus, regardless of the causes of action alleged in plaintiffs' state counterclaim, state courts cannot provide plaintiffs with the relief that is available in federal court.

No. 00-4598, 2000 U.S. Dist. LEXIS 16592, at *21 (S.D.N.Y. Nov. 14, 2000) ("The State Suit cannot adequately protect plaintiffs' rights because the federal courts have exclusive jurisdiction over plaintiffs' ERISA claim.); *see also Magna Group, Inc. v. Gordon Floor Covering, Inc.*, No. 3-99-1926, 2000 U.S. Dist. LEXIS 6067, at *11 (N.D.Tex. May 4, 2000) ("This factor has weighed against abstention in cases where the state court may not have had authority to exercise jurisdiction over the subject matter of a party's claims .") (citations omitted).

After weighing all of the *Colorado River* factors, I conclude that Educators has failed to overcome the strong presumption in favor of exercising federal jurisdiction, and thus, I will deny its motion to dismiss. *See Ryan*, 115 F.3d at 200.

IV. CONCLUSION

Because the state and federal proceedings are not parallel, and because Educators has failed to show the type of "exceptional" circumstances that warrants *Colorado River* abstention, I will not abstain from considering plaintiffs' suit and I will deny the present motion to dismiss. An appropriate order follows.

Appendix C

ORDER

AND NOW, this ___ day of May, 2005, upon consideration of defendant Educators Mutual Life Insurance's motion to dismiss (Doc. No. 3) and plaintiffs Harold L. Leonard and the Leonard Clinic of Chiropractic's opposition thereto (Doc. No. 5), it is hereby ORDERED that the motion is denied.

William H. Yohn, Jr., J.

APPENDIX D — REGULATION INVOLVED

TITLE 29—LABOR
[Revised as of July 1, 1999]

CHAPTER XXV—PENSION AND WELFARE BENEFITS ADMINISTRATION, DEPARTMENT OF LABOR

PART 2560—RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT

§ 2560.503-1 Claims procedure.

(h) Decision on review. (1)(i) A decision by an appropriate named fiduciary shall be made promptly, and shall not ordinarily be made later than 60 days after the plan's receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of a request for review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary, which holds regularly scheduled meetings at least quarterly, a decision on review shall be made by no later than the date of the meeting of the committee or board which immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a decision may be made by no later than the date of the second meeting following the plan's

receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review.

(2) If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.

(3) The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent plan provisions on which the decision is based.

(4) The decision on review shall be furnished to the claimant within the appropriate time described in paragraph (h)(1) of this section. If the decision on review is not furnished within such time, the claim shall be deemed denied on review.

Appendix D

TITLE 29—LABOR
[Revised as of July 1, 2008]

CHAPTER XXV—EMPLOYEE BENEFITS SECURITY ADMINISTRATION, DEPARTMENT OF LABOR

PART 2560—RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT

§ 2560.503-1 Claims procedure.

(f) Timing of notification of benefit determination—(1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination in accordance with paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(i) shall be made in accordance with paragraph (g) of this section. The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of—

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

(ii) Concurrent care decisions. If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments—

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit

determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph (g) of this section, and appeal shall be governed by paragraph (i)(2)(i), (i)(2)(ii), or (i)(2)(iii), as appropriate.

(iii) Other claims. In the case of a claim not described in paragraphs (f)(2)(i) or (f)(2)(ii) of this section, the plan administrator shall notify the claimant of the plan's benefit determination in accordance with either paragraph (f)(2)(iii)(A) or (f)(2)(iii)(B) of this section, as appropriate.

(A) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(iii)(A) shall be made in accordance with paragraph (g) of this section.

(B) Post-service claims. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such

an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(4) Calculating time periods. For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a

claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(g) Manner and content of notification of benefit determination.

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant—

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures,

including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) Appeal of adverse benefit determinations.

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination

and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

APPENDIX E — LETTER TO HAROLD L. LEONARD FROM EASTERN LIFE AND HEALTH INSURANCE COMPANY DATED AUGUST 11, 2006

Eastern Insurance Holdings, Inc.
Eastern Alliance Insurance Company
Allied Eastern Indemnity Company
Eastern Life and Health Insurance Company
Employers Alliance, Inc.

August 11, 2006

Harold L. Leonard
194 West Grant Avenue
Vineland, NJ 08360

Re: Determination of Coverage for Benefits to Harold L. Leonard and Diane M. Leonard

Dear Mr. Leonard:

Please accept this letter as the determination of coverage by Educators Mutual Life Insurance Company, now Eastern Life and Health Insurance Company ("Educators"), as the administrator of an employee benefit group insurance plan. Specifically, this decision addresses the claims of Harold L. Leonard and Diane M. Leonard for medical insurance benefits under a group medical insurance plan issued by Educators to the Leonard Clinic of Chiropractic ("Clinic").

Appendix E

I. Procedural Facts

In July, 1990, the Clinic applied for group medical and group life insurance coverages for its employees through Educators. At the time of the application, Harold L. Leonard was licensed as a doctor of chiropractic in the Commonwealth of Pennsylvania and operated his chiropractic business at 1285 Manheim Pike, Lancaster, Pennsylvania 17601, under the name of the Clinic. Also as of July, 1990, Diane Leonard was the wife of Harold Leonard, and she was represented to Educators as being employed on a full-time basis by the Clinic as the Clinic's office manager. In reliance upon the representations of the Clinic and individual employees of the Clinic, and consistent with its normal practices, Educators issued a master policy to the Clinic and certificates of insurance to the three identified employees, which included Harold Leonard and Diane Leonard. As a result, Educators was providing medical insurance and life insurance to Harold Leonard and Diane Leonard.

On an annual basis, Educators reviewed the policies, the Clinic's claims history, and the Clinic's demographics for rating purposes. This included the size of the group, the location of the group, the sex and age of the members of the group and industry codes. Based upon information available to Educators and the lack of any contrary information from the Clinic's broker, the Clinic, and/or from either of the Leonards, Educators offered the Clinic renewal coverages on an annual basis, and the coverage was renewed.

Appendix E

From the effective date of the coverage until approximately 2003, Educators paid all claims submitted for medical insurance benefits per the terms and conditions of the policies. By 2003, Educators had received bits of information suggesting that the Clinic might not be an active business operation, and similarly suggesting that Harold Leonard and Diane Leonard might not be "actively at work" for the Clinic or "performing all of the duties of [their] job with [the Clinic] on a full-time basis." Thus, Educators began an investigation to determine answers to these questions, which in turn directly impacted on the Leonards' eligibility for benefits.

By September, 2003, Educators had obtained what information it could independently, and determined that it would now approach the Leonards directly for information. To do so, Educators engaged outside counsel for assistance. On September 15, 2003, counsel for Educators wrote to both Harold Leonard and Diane Leonard requesting documentation to establish the Clinic was an active business operation and that Harold Leonard and Diane Leonard were "actively at work" for the Clinic. Concurrent with the request for information, counsel for Educators informed both Harold Leonard and Diane Leonard that none of their outstanding medical claims would be processed pending Educators' investigation.

Neither Harold Leonard nor Diane Leonard provided any of the requested information, and, through his counsel, Harold Leonard demanded payment of the outstanding medical claims.

Appendix E

On April 7, 2004, Educators filed suit in the Court of Common Pleas of Lancaster County, Pennsylvania against Harold Leonard, Diane Leonard and the Leonard Clinic of Chiropractic, asserting fraud on behalf of one or more of the Leonard Defendants.

Specifically, Educators asserted that one or more of the Leonard Defendants had made various representations to Educators indicating that the Clinic was an ongoing business and that Harold Leonard and Diane Leonard were active employees of the Clinic. Educators further asserted that, based on its investigation, the facts were to the contrary and that since at least December, 1997, the Clinic was no longer an active business operation and that neither Harold Leonard nor Diane Leonard were full-time employees of the Clinic. In its complaint, Educators sought a declaration that the group coverage issued to the Clinic and the certificates of coverage issued to Harold Leonard and Diane Leonard be declared null and void since at least December 1, 1997. Additionally, Educators sought recovery for benefits paid since December 1, 1997 in excess of premiums paid.

On December 10, 2004, Harold Leonard and the Leonard Clinic of Chiropractic filed an action in the U.S. District Court for the Eastern District of Pennsylvania seeking reimbursement for unpaid medical expenses pursuant to the Employee Retirement Income Security Act ("ERISA"). Discovery proceeded concurrently under both the state action and the federal action during 2005. The federal action was called to trial on January 9, 2006. Ultimately, the Court and the parties agreed that the

final determination by the administrator had not been made, and that the administrative record had not been completed. Additional discovery, including depositions and document productions, was conducted, and the parties now agree the administrative record is complete.

II. Administrative Record

The administrative record reviewed by Educators for this decision includes the entire Educators file as produced during discovery, as well as all of the additional information produced or developed during discovery, including, but not necessarily limited to, the following:

- Interrogatory answers and documents produced by Harold Leonard;
- Interrogatory answers and documents produced by Diane Leonard;
- Documents produced by Murray Insurance and/or Paul Rovnak;
- Documents produced by J.C. Snyder & Company/Heritage Insurance and/or John C. Snyder;
- Documents identified as potential trial exhibits by Harold Leonard and by Educators;

Appendix E

- Transcripts of the deposition testimony of Harold Leonard, Diane Leonard, Kimberly A. Rankin, Paul Rovnak, John C. Snyder and Greta Aul;

- Documents produced or identified in the depositions identified above;

- Affidavit of Harold Leonard dated July 10, 2006.

III. Educators' Decision

Based on the review of the entire administrative record, and for the reasons discussed below, Educators has concluded that Harold Leonard, in his effort to maintain the group coverage offered by Educators, misrepresented material facts to Educators, and specifically misrepresented the Clinic as an operational business located at 1285 Manheim Pike, Lancaster, Pennsylvania, misrepresented the Clinic as his employer, misrepresented his individual status as a chiropractor licensed in Pennsylvania, misrepresented his individual status as a full-time employee of the Clinic, and misrepresented Diane Leonard's status as a full-time employee of the Clinic. Had the true facts been made known to Educators, neither Harold Leonard nor Diane Leonard would have been eligible for coverage as of December 1, 1997, and possibly much earlier. Accordingly, Educators concludes that rescission of the coverage as of December 1, 1997 is appropriate, and

therefore none of the outstanding medical expenses (all of which were incurred after December 1, 1997) are payable.[1]

IV. Discussion

As noted above, in July, 1990, the Clinic applied to Educators for group medical and group life insurance

1. In a recent submission to Educators, Harold Leonard's attorney contends that Educators never made a determination of benefits and never issued any explanation of benefits ("EOB's"). To the contrary, when Educators began to question the eligibility of the Leonards, Educators issued EOB's indicating that outstanding medical bills would not be paid, and benefits would not be issued, unless and until information was provided to Educators establishing the Leonards' eligibility. This in fact constituted a denial of benefits. In filing suit in the Court of Common Pleas of Lancaster seeking a rescission of coverage, Educators was looking to resolve the issue of whether the Leonards had any additional information regarding their eligibility, in effect initiating the appeal process from Educators' earlier decision not to pay benefits. By Leonard filing an action in federal court under ERISA seeking payment of benefits, Leonard in effect transferred the appeal of the earlier Educators' decision denying benefits from state court to federal court. Nevertheless, at the hearing in federal court on January 9, 2006, the parties and the Court noted the absence of a formal decision by Educators on Leonard's "appeal" and the absence of a complete administrative record being presented to the Court. This letter constitutes Educators' determination of Leonard's appeal and describes the entire administrative record. The parties have essentially agreed that this concludes the administrative process, including any administrative appeal process.

coverages for its employees, Harold Leonard, Diane Leonard and a third employee. In reliance upon the representations of the Clinic and the individual employees, and consistent with its normal practices, Educators issued a master policy to the Clinic and certificates of insurance to the three identified employees, which included Harold Leonard and Diane Leonard, providing medical insurance and life insurance to Harold Leonard, Diane Leonard and a third employee. In addition to the master policy and certificates of insurance issued by Educators, Educators also provided the Clinic with "Group Administration Manuals."

The master policy issued to the Clinic, the certificates of insurance issued to the Clinic's employees, and the Group Administration Manuals delivered to the Clinic, individually and in combination, made clear that Educators was issuing group coverage to an employer for the employer's employees. Thus, for the Clinic to be an eligible employer, it needed to be an ongoing business operation with at least three full-time employees (under HIPPA, the minimum number of employees to qualify for group coverage was reduced to two in 1996), working at least 30 hours per week and compensated for their services. Conversely, for the Clinic's employees to be individually eligible for insurance coverage, each employee needed to be working at least 30 hours per week in the operation of the employer's business, and receiving full compensation for the employment services.

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Unknown to Educators, in 1993, Leonard sold the Clinic to another chiropractor, Dr. Czop. Unknown to Educators, effective January 1, 1994, Dr. Czop began operating the chiropractic business at 1285 Manheim Pike, Lancaster, Pennsylvania, and neither Harold Leonard nor Diane Leonard were employees of Dr. Czop. Harold Leonard did not notify Educators that he had sold the Clinic nor that Dr. Czop was operating the chiropractic business at 1285 Manheim Pike, Lancaster, Pennsylvania.

Unknown to Educators, in February, 1994, Harold Leonard returned to school at the University of Delaware, seeking a degree in physical therapy. He continued his course of study through 1994 and into 1995, and the course of study included clinical experiences in physical therapy in the Reading area. Harold Leonard did not notify Educators that he returned to school studying for a degree in physical therapy.

Unknown to Educators, effective June 1, 1995, Leonard's Pennsylvania chiropractic license was placed on inactive status for a five-year period. Accordingly, Harold Leonard could not practice as a chiropractor in Pennsylvania after June 1, 1995. Harold Leonard did not notify Educators that, effective June 1, 1995, his chiropractic license was placed on inactive status and that he could not practice as a chiropractor in Pennsylvania after June 1, 1995. Unknown to Educators, Leonard never renewed his license to practice as a chiropractor in Pennsylvania. Hence, after June 1, 1995,

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Leonard was never an active, practicing chiropractor in Pennsylvania.

Unknown to Educators, in September, 1995, Leonard opened a chiropractic clinic in Ellicott City, Maryland. Initially, the clinic was affiliated with and opened under the name of the Yalich Clinic of Ellicott City. After Harold Leonard discontinued his affiliation with the Yalich Clinic, he began operating under the name of the "Back & Neck Pain Treatment Center of Ellicott City." Harold Leonard did not notify Educators that, in September, 1995, he opened a chiropractic clinic in Ellicott City, Maryland and was practicing in Ellicott City, Maryland.

Diane Leonard apparently provided services to Harold Leonard as an office manager in this clinic, although she was not compensated for these services. Harold Leonard did not notify Educators that as of September, 1995, Diane Leonard was providing services to a chiropractic clinic based in Ellicott City, Maryland, without being compensated for her services.

Unknown to Educators, in June, 1997, Diane Leonard separated from Harold Leonard and ceased providing any services to Harold Leonard's clinic in Maryland. Harold Leonard did not inform Educators that, in June, 1997, Diane Leonard ceased providing any services to Harold Leonard's clinic in Maryland.

Therefore, as of October, 1997, Leonard was no longer a licensed chiropractor in Pennsylvania, the Clinic was no longer operating at 1285 Manheim Pike, Lancaster,

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Pennsylvania, Leonard's chiropractic business, such as it was, did not have the minimum of two covered employees, and Diane Leonard had no employment relationship with the Clinic.

Notwithstanding these facts, in October, 1997, Harold Leonard submitted an "Employer's Application for Group Medical Insurance" for his employees as part of an application for a change in medical insurance coverage through Educators, converting the medical insurance from an indemnity plan to a PPO plan. On the application, Leonard identified the name of the business as the Leonard Clinic of Chiropractic and the location of the business as 1285 Manheim Pike, Lancaster, Pennsylvania. As part of the October, 1997 application process, Harold Leonard submitted an individual application for himself, indicating that he was actively and regularly working at least 30 hours a week for the Clinic (which was identified in the companion employer application as being located at 1285 Manheim Pike, Lancaster, Pennsylvania). As part of the October, 1997 application process, Harold Leonard also submitted an individual application for Diane Leonard, identifying Diane Leonard as the office manager of the Leonard Clinic of Chiropractic (identified in the employer's application as operating at 1285 Manheim Pike, Lancaster, Pennsylvania) and further representing that she was working 35 hours per week for the Clinic. Harold Leonard forged Diane Leonard's signature on the individual application.

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On December 2, 1997, Harold Leonard resubmitted the employer's application for medical insurance for the Clinic's employees, again identifying the address of the Clinic as 1285 Manheim Pike and again identifying two eligible employees, presumably Harold Leonard and Diane Leonard. Harold Leonard did not notify Educators at the time of these applications that the Clinic was not operating at 1285 Manheim Pike, Lancaster, Pennsylvania, and that Diane Leonard was not employed on a full-time basis by the Clinic.

Virtually all of the material information provided by Harold Leonard on the October, 1997 and December, 1997 applications was false, intended to mislead Educators into extending medical insurance when neither Harold Leonard nor Diane Leonard were eligible for insurance coverage.

Unknown to Educators in Fall, 1998, Harold Leonard discontinued treating patients at his Maryland clinic, although Harold Leonard retained the services of another chiropractor to see and treat his patients. Unknown to Educators, in September, 1999, Harold Leonard entirely closed his Maryland clinic. Notwithstanding these significant changes to his business operations, and in fact the termination of the business entity to which the master policy was issued, Harold Leonard never notified Educators that he had discontinued treating patients (in Fall, 1998) and that he closed his Maryland clinic (in September, 1999).

Incredibly, about one year later, Harold Leonard again completely misrepresented the true status of his business operations. As a result of certain inquiries from Murray Insurance Associates, Leonard's broker, Harold Leonard signed a document on or about August 7, 2000, intended to provide information about the Clinic. Notwithstanding the fact that Harold Leonard had not operated a Clinic at 1285 Manheim Pike, Lancaster, Pennsylvania since 1993 and notwithstanding the fact that Harold Leonard had not operated any chiropractic clinic since 1999, Harold Leonard signed the verification form representing that 1285 Manheim Pike, Lancaster, Pennsylvania continued to be the primary location for the Leonard Clinic of Chiropractic and that the address in Ellicott City, Maryland was solely the mailing address for premium notices.[2]

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2. Harold Leonard has expressly and/or implicitly argued that he simply relocated his chiropractic business from 1285 Manheim Pike Lancaster, Pennsylvania to Ellicott City, Maryland, and that this should not have had any impact on his insurance coverage. To the contrary, the relocation of the practice across state lines would have had an impact, and possibly a significant impact, on the medical insurance coverage and the premium structure. Some states, such as Maryland, and unlike Pennsylvania, impose structured group medical benefits and pricing requirements. In other words, a group medical insurance plan issued to a Maryland employer would have had a different benefit structure than a group plan issued to a Pennsylvania employer and would likely have had a higher premium. Furthermore, geography is critical to a PPO plan such as Leonard had converted to in 1997. A PPO plan requires a series of contractual agreements with local healthcare providers

(Cont'd)

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V. Conclusion

Clearly, as of December 1, 1997, the Clinic in terms of a Lancaster-based business was no longer in operation. Even if Harold Leonard was still actively engaged in practice as a chiropractor, he was a sole practitioner with no employees. For a group policy to exist, the employer must have at least two full-time employees. At no time after December 1, 1997 did the Clinic (practicing under any name) have two full-time employees. More importantly, neither Harold Leonard nor Diane Leonard was, at any time after December 1, 1997, working at least 30 hours per week in the operation of the Clinic's business, receiving full compensation for these services. In short, neither Harold Leonard nor Diane Leonard are eligible for coverage under the policy after December 1, 1997. At the same time, Harold Leonard consistently misrepresented material facts regarding the operation of the business, regarding the location of the business, regarding Harold Leonard's status as an the employee of the Clinic and regarding Diane Leonard's status as an employee of the Clinic.

(Cont'd)
which in turn forms a PPO network. The financial arrangements of that PPO network can also impact premiums. In short, a PPO plan for the Clinic based in Ellicott City, Maryland, even with similar coverages, would have faced higher premium costs when compared to a PPO plan for the Clinic based in Lancaster, Pennsylvania (as was represented to Educators). Furthermore, all of this misses the point that Leonard never had two full-time covered employees in the Maryland practice, a requirement for the business to be eligible for group coverage.

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As revealed during Educator's investigation, following the separation of Harold and Diane Leonard in June, 1997, divorce proceedings were commenced. On December 5, 1997, an interim order of court directed Harold Leonard to provide medical insurance coverage to Diane Leonard. In other words, Harold Leonard, as part of the divorce proceedings with Diane Leonard, was obligated to provide medical insurance coverage to Diane Leonard. Since Diane Leonard was no longer an employee of the Clinic, and since the Clinic was no longer eligible for group coverage, Harold Leonard would have been required under the Court Order to purchase individual coverage for Diane Leonard and for himself, which would have been substantially more expensive than the cost of the group coverage he was fraudulently obtaining from Educators. Furthermore, and important to note, Educators did not offer or issue individual medical insurance plans. Hence, had Harold Leonard revealed the true facts to Educators, Harold Leonard could not have obtained any medical insurance coverage from Educators.

Educators has reasonably concluded that the higher-cost individual insurance which Harold Leonard would have been obligated to provide to Diane Leonard, but which he could not obtain from Educators, motivated Harold Leonard to misrepresent facts to Educators. Accordingly, Educators has concluded that in light of the Leonards' ineligibility for coverage and in light of the misrepresentations made by Harold Leonard, the medical insurance coverage is appropriately rescinded as of December 1, 1997.

Sincerely,

EASTERN LIFE AND HEALTH INSURANCE COMPANY

s/ Kimberly A. Rankin
Kimberly A. Rankin
Vice President & Corporate Secretary

APPENDIX F — LETTER TO MR. AND MRS. LEONARD FROM GEORGE C. WERNER, ESQ. DATED SEPTEMBER 15, 2003

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George C. Werner, Esquire
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September 15, 2003

Harold L. Leonard
5525 Twin Knolls Road
Columbia, MD 21045-3207

Diane Leonard
P.O. Box 1433
Levittown, PA 19058

Re: Group Coverage for Leonard Clinic of Chiropractic

Dear Dr. Leonard and Mrs. Leonard:

My firm is general counsel to Educators Mutual Life Insurance Company ("Educators"), and I have been asked to assist Educators in its investigation of the employee group insurance coverage obtained by the Leonard Clinic of Chiropractic ("Clinic") through Educators.

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In July, 1990, the Clinic submitted an application to Educators seeking group medical insurance and group life insurance with accidental death and dismemberment for the Clinic's employees. As both of you are aware, to be eligible for employee group coverage, Educators required an active employer business operation and a minimum of three covered employees for each line of coverage provided by Educators. Furthermore, in addition to these "group" requirements, coverage for each individual employee required that a covered employee be "actively at work."

Educators has information indicating that, for several years, the Clinic has not been an active employer business operation, and that neither of you have been "actively at work" for the Clinic.

As part of its investigation, Educators needs to review documents, if they exist, demonstrating that the Clinic was an active business operation, and that both of you were actively at work for the Clinic. Accordingly, for each of the calendar years beginning 1990 through the current, please provide the following:

- All financial statements for the Clinic;
- All federal, state and local tax returns filed by the Clinic;
- All UC-2 reports submitted by the Clinic to the state;

Appendix F

- Any other reports, forms or filings submitted by the Clinic to federal, state or local government, such as tax forms, insurance forms, health care provider forms, etc., demonstrating that the Clinic was an active employer;

- Banking records, checking account statements, etc., demonstrating revenues into and expenses paid by the Clinic;

- Bookkeeping records of the Clinic, demonstrating revenues into and expenses paid by the Clinic;

- Real estate documents/leases etc. entered into by the Clinic, property tax receipts and other documentation reflecting the Clinic's ownership/possession and use of real estate in furtherance of its business operations;

- Invoices and other documentation reflecting the Clinic's purchase of goods and services in furtherance of its business operations;

- W-2's, 1099's, payroll check stubs, and similar documentation reflecting payment of salary, wages, etc. by the Clinic to: 1) Dr. Leonard; 2) Diane Leonard; and 3) other "covered" employees of the Clinic;

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- Federal, state and local tax returns of Dr. Leonard and Diane Leonard reflecting reported income from the Clinic; and

- Any other reports or documents demonstrating that Dr. Leonard and Diane Leonard were actively at work for the Clinic.

Educators has medical claims outstanding for both of you. Educators will not process these claims any further until this investigation can be completed. If the investigation establishes that the employer group ceased to be active and/or that either one of you were not actively employed by the Clinic prior to the dates of services for the pending medical claims, coverage for the pending medical expenses may be affected. Educators' investigation may raise additional issues and claims.

Furthermore, if the evidence establishes that the Clinic is no longer an active employer and/or that either one of you are not or have not been actively at work for the Clinic, the group life insurance coverage may be similarly affected.

I recognize that you may not be able to assemble all of the requested information immediately. Please provide what documentation you can as soon as possible and supplement the documentation as quickly as you are able to assemble it.

Appendix F

If you have any questions, please contact me.

Sincerely yours,

s/ George C. Werner
George C. Werner

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No. 08-989

IN THE

Supreme Court of the United States

HAROLD L. LEONARD
d/b/a THE LEONARD CLINIC OF CHIROPRACTIC,
Petitioner,

v.

EDUCATORS MUTUAL LIFE INSURANCE COMPANY,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

RESPONDENT EDUCATORS MUTUAL LIFE INSURANCE COMPANY'S BRIEF IN OPPOSITION

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March 6, 2009

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

COUNTERSTATEMENT OF THE QUESTION FOR REVIEW

Whether the Third Circuit erred in summarily affirming the district court's determination that petitioner was ineligible for insurance coverage because of his intentionally misleading statements.

CORPORATE DISCLOSURE AGREEMENT PURSUANT TO SUPREME COURT RULE 29.6

After initiation of this litigation, Educators Mutual Life Insurance Company changed its name to Eastern Life & Health Insurance Company. Eastern Life & Health Insurance Company converted from a mutual company to a stock company and formed Eastern Insurance Holdings, Inc. Ultimately, Eastern Life & Health Insurance Company became and is a wholly-owned subsidiary of Eastern Insurance Holdings, Inc. As part of this process, Eastern Insurance Holdings, Inc. purchased all of the outstanding stock of Eastern Holding Company Ltd. and its wholly-owned subsidiaries, Eastern Alliance Insurance Company, Allied Eastern Indemnity Company, Employers Alliance, Inc., Global Alliance Holdings, Ltd., Global Alliance Statutory Trust I, Eastern Services Corporation, and Eastern Re Ltd. S.P.C.

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On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

RESPONDENT EDUCATORS MUTUAL LIFE INSURANCE COMPANY'S BRIEF IN OPPOSITION

INTRODUCTION

Petitioner Harold L. Leonard ("Leonard") intentionally misrepresented material facts to Educators Mutual Life Insurance Company ("Educators") to obtain health insurance from Educators, and he continued to misrepresent facts over a period of several years. Under the "true" facts, Leonard was not eligible for coverage, and once Educators learned these facts, Educators ceased paying benefits and

informed Leonard in a letter of the reason it was no longer paying benefits. The district court reviewed the record and concluded that more than ample evidence supported Educator's determination. The court of appeals affirmed the district court's decision for the same reasons.

In his Petition, Leonard seeks to have this Court consider the question of what standard of review should be utilized by the courts in reviewing an ERISA plan administrator's action where the administrator has not exercised discretion in making an eligibility determination. Petitioner argues that the court should utilize the *de novo* standard of review as opposed to an arbitrary and capricious standard of review, and Petitioner suggests the circuits are split on this issue.

The circuit conflict to which the Petitioner points, to the extent it exists, is not relevant to this case. This case does not involve a factual scenario where the plan administrator failed to exercise discretion in an eligibility determination. Furthermore, this case does not even present the situation where the plan administrator did not timely exercise discretion in an eligibility determination. Educators timely exercised its discretion which the district court implicitly recognized. Furthermore, even if the *de novo* standard, as opposed to the arbitrary and capricious standard, is applied here, the outcome would not change. The district court made clear that, even under a *de novo* standard of review, Educators' decision to terminate benefits would be upheld.

COUNTERSTATEMENT OF THE FACTS

In July, 1990, The Leonard Clinic of Chiropractic ("Clinic")[1] applied for group medical and group life insurance coverage for its employees through Educators. At the time of the application, Leonard was licensed as a doctor of chiropractic in Pennsylvania and operated his business in Lancaster, Pennsylvania under the name of the Clinic. Diane Leonard, the wife of Leonard, was represented to Educators as employed on a full-time basis by the Clinic as its office manager. In reliance upon the representations of the Clinic and of the individual employees of the Clinic, and consistent with its normal practices, Educators issued a master policy to the Clinic and certificates of insurance to the three identified employees.

For the Clinic to be an employer eligible for group coverage for employees, the Clinic needed to be an ongoing business operation with at least three full-time employees (later reduced to two) working at least 30 hours per week and compensated for their services. For an individual employee to be eligible for the group coverage, the individual employee needed to be working at least 30 hours per week in the operation of the Clinic's business and receiving full compensation for the employment services.

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[1] Before the court of appeals and in his Petition, Leonard has identified himself as the "Clinic." However, in the district court, Leonard recognized the distinction between himself and the Clinic. The caption of the case, as filed in the district court, is "Harold L. Leonard and the Leonard Clinic of Chiropractic." In the complaint as filed in the district court, Leonard indicated there were two plaintiffs, Leonard individually and the Clinic, and throughout the numbered paragraphs, the complaint referenced Leonard and the Clinic as two separate entities.

In the years following 1990, during the renewal process, Leonard continued to represent to Educators that the Clinic was an ongoing business conducting operations in Lancaster, Pennsylvania, with two eligible (full-time, compensated) employees. Leonard also continued to represent that he and his wife were working full time (at least 30 hours per week) for the Clinic.

However, none of those representations, all material to coverage, was true. In the years prior to 2003, the Clinic had ceased business operations, Leonard was no longer a licensed chiropractor in Pennsylvania, and neither Leonard nor his wife was employed in any capacity by the Clinic, let alone employed full-time.

In 2003, Educators obtained information that the Clinic was not an active business operation and that the Leonards were not full-time employees of the Clinic. Educators, as the plan administrator, made a benefits determination in 2003, informing both Harold Leonard and Diane Leonard in a letter that no further benefits would be paid because they were not full-time employees for the Clinic (Pet. App. 96a). At the same time, Educators invited Harold and Diane Leonard to submit additional information, if in fact they were full-time employees of the Clinic. The Leonards did not provide any additional information, and shortly thereafter, Educators initiated a declaratory judgment action in state court. Leonard then initiated the present action in district court. After discovery in the federal court action, the matter was scheduled to proceed as a non-jury trial. However, on the day set for trial, after a discussion with the Judge, the parties agreed not to proceed with a non-jury trial, but rather formalize an administrative

appeal process. Educators thereafter issued a formal written determination, which in effect constituted its determination following an administrative appeal.

The administrative record was then submitted to the district court, which reviewed the record and concluded that ample evidence supported Educators' determination that Leonard was not eligible for benefits. In its written decision, the trial court determined that the appropriate standard of review was the "heightened form of arbitrary and capricious" standard. Although the court employed the arbitrary and capricious standard of review, the district court also made an additional determination, critical here. After reviewing the administrative record, in which the district court found ample evidence to support the administrator's decision under the arbitrary and capricious standard of review, the district court expressly held:

> "I would reach the same result even if I were to apply a de novo standard of review."

(Pet. App. 45a.)

In a memorandum opinion, the court of appeals affirmed the district court for the reasons set forth by the district court. (Pet. App. 1a.)

REASONS FOR DENYING THE PETITION

I. The Factual Record Does Not Raise The Legal Issue Presented By Petitioner.

With the question as presented, Petitioner asks this Court to determine the standard to be applied by courts in reviewing an eligibility determination where the administrator of an ERISA benefit plan has failed to exercise discretion. In other words, the factual predicate to the issue as presented by the

Petitioner requires a record where the administrator of an ERISA benefit plan failed to exercise discretion in an eligibility determination.

This case does not present that question. To the contrary, as established in the letter from Educators to Leonard (Pet. App. 96a), as soon as Educators gathered the facts to support its determination that Leonard was no longer eligible, Educators ceased paying benefits and notified Leonard as to the reason for its decision to terminate the payment of benefits. Therefore, Educators exercised its discretion in the eligibility determination and did so before any litigation occurred.

Furthermore, Leonard never asserted at the district court level that Educators had failed to make a benefits determination. To the contrary, at the district court level, Leonard acknowledged that Educators had exercised its discretion in making an eligibility determination, but argued that the *de novo* standard of review should apply because Educators had allegedly not reserved discretionary authority in the Plan documents. It was not until Petitioner was before the court of appeals that he contended that Educators had failed to exercise its discretion in a timely fashion, arguing that the claims determination first occurred in August, 2006, after commencement of litigation in the district court. As discussed above, Educators' review of the administrative record while the matter was in litigation was part of the administrative appeal process undertaken with the consent of Leonard, not the initial eligibility determination. Educators' initial exercise of discretion in the eligibility determination occurred in 2003.

Not only does the record establish that Educators in fact made an eligibility determination, but the

record establishes, at least implicitly, that the trial court determined Educators had timely exercised its discretion in making an eligibility determination. In effect, Petitioner is now attempting to challenge a factual finding by the district court, a factual finding which was not disturbed by the court of appeals. Such a factual finding plainly does not warrant this Court's review. But with this as a finding of fact, it is established that Educators exercised its discretion and did so in a timely fashion. The district court reviewed the exercise of discretion by Educators. Hence, this case does not present this Court with the question of what is the appropriate standard of review where the administrator has failed to exercise discretion in an eligibility determination.

II. A Different Standard Of Review Will Not Alter The Outcome Of This Case.

Petitioner purports to ask this Court to review the appropriate standard of review under a particular fact pattern (which does not exist here). The district court determined that the appropriate standard of review was a "significantly heightened arbitrary and capricious" standard. Petitioner had argued for the district court to apply a *de novo* standard. The ultimate relief Petitioner is asking, if this case were to be reversed by this Court, is to have the district court review Educators' eligibility determination under a *de novo* standard of review. However, the district court has already done so and rejected Petitioner's claim.

At the end of its thorough opinion, the district court concluded that the record supported Educators' denial of benefits under the significantly heightened arbitrary and capricious standard of review. Then, the court expressly stated that the record also sup-

ported Educators' denial of benefits even under a *de novo* standard of review. The court stated:

> "I would reach the same result even if I were to apply a de novo standard of review."

(Pet. App. 45a.)

The facts supporting Educators' decision to deny benefits to Leonard were so compelling that the standard of review is irrelevant. Consequently, this Court's determination of the question as presented by the Petitioner will have no effect upon the outcome of this case. Accordingly, this case presents an unusually "poor vehicle" for this Court to resolve any potential circuit conflict.[2] Eugene Gressman, *et al.*, *Supreme Court Practice* 504 (9th ed. 2007).

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[2] The circuit split identified by the Petitioner, on the issue of the appropriate standard of review to be applied where the administrator fails to exercise discretion, represents varying factual analyses by the circuits, as much as it represents a divergence in legal principles to be applied. In some cases, the courts are addressing a situation where the administrator has not exercised discretion at all. In other cases, the administrator has exercised discretion, but arguably did not do so in a "timely" fashion. Some courts then struggle with the question of whether the administrator was in substantial compliance with any time constraints, although not technically timely. Finally, in other cases, the courts struggle with an administrator's discretion which is not exercised until after the initiation of litigation by a claimant. Reviewed through this prism, the reported decisions reflect cases that turn on a fact specific analysis rather than different results caused by a circuit split on a legal issue. More importantly, for the reasons discussed above, the administrator's decision here would be upheld under any standard of review.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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March 6, 2009